Mental Health Services Act
Prevention & Early Intervention

ALAMEDA COUNTY
PROPOSED THREE-YEAR
PROGRAM & EXPENDITURE PLAN
FYS 2007-2008, 2008-2009

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PEI COMPONENT OF THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN FACE SHEET

Form No. 1

MENTAL HEALTH SERVICES ACT (MHSA)
PREVENTION AND EARLY INTERVENTION COMPONENT
OF THE THREE-YEAR
PROGRAM AND EXPENDITURE PLAN
Fiscal Years 2007-08 and 2008-09

County Name: Alameda County	Date:

COUNTY'S AUTHORIZED REPRESENTATIVE AND CONTACT PERSON(S):

County Mental Health Director	**Project Lead**
Name: Marye Thomas, MD	Name: Gary Spicer
Telephone Number: (510) 567-8100	Telephone Number: (510) 567-8122
Fax Number: (510) 567-8180	Fax Number: (510) 567-8130
E-mail: mthomas@acbhcs.org	E-mail: gspicer@acbhcs.org
Mailing Address: Alameda County Behavioral Health Care Services Agency 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606	

AUTHORIZING SIGNATURE

I HEREBY CERTIFY that I am the official responsible for the administration of Community Mental Health Services in and for said County; that the county has complied with all pertinent regulations, laws and statutes. The county has not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and the administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2007-08, 2008-09 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief the administration budget and all related program budgets in all respects are true, correct and in accordance with the law. I have considered non-traditional mental health settings in designing the County PEI component and in selecting PEI implementation providers. I agree to conduct a local outcome evaluation for at least one PEI Project, as identified in the County PEI component (optional for "very small counties"), in accordance with state parameters and will fully participate in the State Administered Evaluation.

Signature _____ 8-18-08

County Mental Health Director Date

Executed at OAKLAND, California

Mental Health Services Act
Prevention & Early Intervention

ALAMEDA COUNTY
PROPOSED THREE-YEAR PROGRAM & EXPENDITURE PLAN
FYS 2007-2008, 2008-2009

EXECUTIVE SUMMARY

CONTENTS

I. BACKGROUND

The intent of the PEI strategies is to engage persons prior to the development of serious mental illness or serious emotional disturbances, or, in the case of early intervention, to alleviate the need for additional mental health treatment and/or to transition to extended mental health treatment.

PEI funding is to be used to achieve specific PEI outcomes for individuals, programs/systems and communities. PEI funding may support relatively short duration and low intensity approaches to achieve intended outcomes, *not* for filling gaps in treatment and recovery services for individuals who have been diagnosed with a serious mental illness or serious emotional disturbance and their families.

Exception for Early Onset of a Serious Psychiatric Illness with Psychotic Features: The standards of low intensity and short duration do not apply to services for individuals experiencing early onset of a serious psychiatric illness with psychotic features that receive this type of transformational intervention.

Alameda County will be allocated approx. $7.2 million per year for PEI implementation. BHCS administration will retain 15% ($1.08M) for infrastructure and the remaining 85% ($6.12M) will go towards programs. The following funding parameters were established in accordance with State DMH guidelines and local directives:

- All ages must be served;
- At least 51% of the overall PEI budget must be targeted to individuals age 25 and under;
- Disparities in access to services for underserved ethnic communities that were not well-funded through CSS due to their lower utilization of mental health services must be addressed;
- All regions of the County must have access to services.

II. COMMUNITY PLANNING PROCESS

Our local planning process was designed to elicit input from numerous and diverse stakeholders especially consumers, family members and members of underserved ethnic and language groups :

- Over 600 community members participated in 8 large community input meetings and 25 focus group meetings in every region of the County (November – December 2007);
- Over 1000 community members completed our survey on prevention/early intervention needs
- Community-based organizations and coalitions submitted 25 community reports detailing their most recent research and findings regarding community needs and effective PEI strategies;
- Planning Panels analyzed community input and developed 17 priority strategies
- The MHSA Ongoing Planning Council, representing a diverse set of stakeholders including consumers, family members, providers and BHCS administration, reviewed the 17 strategies and directed BHCS staff to design programs with full budget information for 13 strategies.

III. PROGRAMS

*PEI Programs are required to address one or more of the following Community Mental Health Needs:

1. **Disparities in Access to Mental Health Services:** reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services or lack of suitability (i.e., cultural competency) of traditional mainstream services.
2. **Psycho-Social Impact of Trauma:** reduce the negative psycho-social impact of trauma on all ages.
3. **At-Risk Children, Youth and Young Adult Populations:** increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.
4. **Stigma and Discrimination:** reduce stigma and discrimination affecting individuals with mental illness and mental health problems.
5. **Suicide Risk:** increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.

Ten of the strategies that were budgeted were prioritized by the Ongoing Planning Council for implementation. Table 1 provides a summary of all the recommended programs.

As shown in Table 1, many of the PEI Projects were developed to address the specific cultural needs of underserved age and ethnic groups. It is the intent of the Ongoing Planning Council that the PEI Projects will also support additional high need groups such as African Americans who are over/inappropriately served by the mental health system, and the physically disabled and lesbian, gay bisexual, transgender, queer, questioning and intersexed (LGBTQQI) communities who are underserved. For example, it is anticipated that approximately 30% of those receiving community-based treatment services under Project 2 will be African American. African Americans will also be served under projects 1, 3 and 4.

Table 1. Proposed Prevention & Early Intervention Programs

Program	Program Description	Community Mental Health Needs addressed	Approx. annual unduplicated clients served		Annual PEI Budget
1.A. School-Based Mental Health Consultation in Preschools	*Outreach, on-site mental health consultation, screening and evaluation at preschools.*	1- Disparities 2- Trauma 3- At Risk Pops 4- Stigma & Discrim 5- Suicide Risk	Individuals	Families	$212,632
			280*		
1.B. School-Based Mental Health Consultation in Elementary & Middle Schools	*Outreach, on-site mental health consultation,screening and evaluation at elementary and middle schools.*	1- Disparities 2- Trauma 3- At Risk Pops 4- Stigma & Discrim 5- Suicide Risk	1575*		$528,015
1.C. School-Based Mental Health Consultation in High Schools	*Outreach, on-site mental health consultation, screening and evaluation at high schools.*	1- Disparities 2- Trauma 3- At Risk Pops 4- Stigma & Discrim 5- Suicide Risk	3535*		$289,546
2. Early Intervention for the Onset of First Psychosis & SMI Among Transition Age Youth	*Outreach, education and early treatment for TAY experiencing the onset of mental illness.*	1- Disparities 2- Trauma 3- At Risk Pops 4- Stigma & Discrim 5- Suicide Risk	392	408	$1,143,890
3. Mental Health-Primary Care Integration for Older Adults	*Inclusion of mental health specialists at community clinics and emergency rooms for screening, brief consultation and referrals of Older Adults, focusing on the API and Latino communities*	1- Disparities 2- Trauma 5- Suicide Risk	215		$733, 152
4. Stigma & Discrimination Reduction Campaign	*Outreach and education, consumer empowerment and local media project.*	4- Stigma & Discrim	10,914	3638	$1,171,501
5. Outreach, Education & Consultation for the Latino Community	*Outreach and education, mental health consultation, and cultural wellness practices for Latino community.*	1- Disparities 2- Trauma 3- At Risk Pops 4- Stigma & Discrim 5- Suicide Risk	613	638	$713,654
6. Outreach, Education & Consultation for the Asian Pacific Islander Community	*Outreach and education, mental health consultation, and cultural wellness practices for Asian Pacific Islander community.*	1- Disparities 2- Trauma 3- At Risk Pops 4- Stigma & Discrim 5- Suicide Risk	490	510	$605,250
7. Outreach, Education & Consultation for the South Asian and Afghan Community	*Outreach and education, mental health consultation, and cultural wellness practices for South Asian & Afghan communities.*	1- Disparities 2- Trauma 3- At Risk Pops 4- Stigma & Discrim 5- Suicide Risk	368	383	$534,856
8. Outreach, Education & Consultation for Native American Community	*Outreach and education, mental health consultation, and cultural wellness practices for Native American community.*	1- Disparities 2- Trauma 3- At Risk Pops 4- Stigma & Discrim 5- Suicide Risk	294	306	$274,582
* School-Based Programs target children, their families and the school staff.				**TOTAL**	**$6,207,078**

IV. REVIEW AND COMMENT

The full draft PEI plan is now available for the state-mandated 30-day public review and comment. Please go to www.acbhcs.org to download the full draft plan or call 510-383-1704 to request a copy. A summary of the plan will be presented and comments taken at the times and locations below. You are invited to attend one of these meetings or submit your comments in writing to mhsa@acbhcs.org, by no later than July 14, 2008. (Please cite the section and page number of the draft plan if you are making a specific comment or suggestion.)

Monday June 23, 2008 (District 2)
4:00pm-6:00pm
Alameda County Community Development Agency
224 W. Winton Avenue - Room 160
Hayward, CA

Tuesday June 24, 2008 (District 3)
3:00pm-5:00pm
First Five Training Center
1100 San Leandro Boulevard - Suite 130
San Leandro, CA

Wednesday June 25, 2008 (District 4)
3:00pm-5:00pm
Wellness Center - Eastmont Mall
6955 Foothill Boulevard - Maxwell & Sobrante Rooms Oakland, CA

Thursday, June 26, 2008 (District 1)
4:00pm-6:00pm
Livermore Public Library
1188 South Livermore Avenue - Community Room A & B
Livermore, CA

Monday June 30, 2008 (District 5)
4:00pm-6:00pm
West Oakland Public Library Branch
1801 Adeline Street - Multi-Purpose Room
Oakland, CA

The Alameda County Mental Health Board will host the final public hearing at their July 14th meeting. After reviewing and accounting for all substantive comments from the public, BHCS will submit the PEI Plan by the end of July for review by the State Oversight & Accountability Commission (OAC).

Upon approval of the plan, BHCS will bring to the Board of Supervisors for adoption our recommendations for the RFP to select individual providers to implement the plan. The RFP will be tied to Alameda County's existing contracting procedures and requirements and be broadly distributed to community based organizations and other relevant provider groups in our County. Services are expected to begin in early 2009.

Instructions: Please provide a narrative response and any necessary attachments to address the following questions. (Suggested page limit including attachments, 6-10 pages)

County: ALAMEDA **Date:** August 18, 2008

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

- Marye Thomas, Mental Health Director
- Barbara Majak, Deputy Director of Mental Health
- Gary Spicer, Director of the Office Management Services (Alameda County MHSA Coordinator)

Supported by the **MHSA Planning Team**:

- Carl Pascual, Senior Planner
- Wendi Wright, Planner
- Linda Leung Flores, Planner
- Gilda Mansour, Planner
- Catherine Chen, Administrative Support Staff

b. Coordination and management of the Community Program Planning Process

The **MHSA Project Management Team (PMT)**:

- Marye Thomas, Mental Health Director
- Barbara Majak, Deputy Director of Mental Health
- Gary Spicer, Director of the Office of Management Services (Alameda County MHSA Coordinator)
- Carolyn Novosel, Director of Children's Services
- Michelle Burns, Director of Transition-Age Youth (TAY) Services
- Peter Alevizos, Director of Adult Services
- Clint Nix, Director of Older Adult Services
- Gigi Crowder, Ethnic Services Manager
- Diana Cunningham, Management Support Services
- Marlene Gold, Finance Director
- Jay Mahler, Consumer Relations Manager
- Sandy Stier, Information Technology Director
- Jerry Fillingim, Service Employees International Union – Local 1021
- Fanya Margot McDaniel, Family Coalition

- Leslie Preston, Alameda Council of Community Mental Health Agencies
- Margaret Walkover & Andree Reyes, Wellness, Recovery & Resiliency Resource Hub Director and Associate Director
- Rosa Warder, Program Director, Family Partnership & Direct Services
- Sarah Wilson, Assistant to Alice Lai-Bitker, District Three Supervisor
- Kathy Zatkin, System Liaison, Alameda County Network of Mental Health Clients

Supported by the **MHSA Planning Team** (as listed above)

c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

The **MHSA Project Management Team** and **MHSA Planning Team** with Outreach Consultants **Health and Human Resource Education Center** (www.hhrec.org).

2. Explain how the county ensured that the stakeholder participation process accomplished the following objectives (please provide examples):

a. Included representatives of unserved and/or underserved populations and family members of unserved/underserved populations

The MHSA Planning Team worked with other ACBHCS staff, outreach consultants Health and Human Resource Education Center (HHREC) and the Alameda County Board of Supervisors to implement an expansive outreach effort to educate members of the community and include them at each stage of the planning process. Efforts were made to provide targeted outreach to groups traditionally underserved by the mental health system and provide opportunities for their meaningful participation throughout the planning process. The process included the engagement of diverse local stakeholders, including those from required strategic sectors, systems and organizations. For example, transition age youth (TAY), parents, and service providers were involved in the development of the TAY Strategic Plan, which guided the forming of the ACBHCS Study Group on Early Intervention at the Onset of Psychosis and the resulting PEI Community Report consisting of recommendations to address TAY needs relating to the onset of psychosis. As another example, an Underserved Ethnic and Language Populations (UELP) Planning Panel was created and designated as one of the two PEI Planning bodies responsible for developing strategies and reporting directly to the Ongoing Planning Council, the primary stakeholder group for MHSA Planning. Consultants were secured to work with the UELP Planning Panel to support their process and the development of PEI strategies.

Members of the community were encouraged to become involved in the PEI Planning Process in a variety of ways. They were invited to participate in Community Input Meetings/Focus Groups; to complete the Community Survey; submit a Community Report to share strategies for addressing community needs; sit on the PEI Planning Panels; fill open seats on the Ongoing Planning Council (OPC); attend the Two-Day Conference summarizing the community input and to attend the public

OPC meetings as the planning process progressed. These opportunities for participation were advertised in the following ways:

- Invitations were sent to everyone that had been involved in the Community Services and Supports (CSS) Process through master email and mailing lists
- Invitations were sent to all organizations on the ACBHCS Community-Based Providers list
- Invitations were issued through local English and Ethnic Language Newspapers
- ACBHCS Internal Staff including the Consumer Relations Manager, the Cultural Competency Manager and the Operational Directors for projects serving the different age groups conducted targeted outreach to individuals and organizations such as those shown in Tables 1 and 2
- Other partners such as Board of Supervisor Staff and Community-Based Organizations (CBOs) that target underserved ethnic and language groups helped to provide further outreach to underserved geographic and ethnic populations

Planning Phase I: Community Input Phase

This initial phase began in November 2007 with eight large Community Input Meetings (shown in Figure 1) throughout the County, which engaged 629 individuals. The eight meetings presented PEI funding guidelines to diverse stakeholders. These meetings also provided an opportunity for individuals to first, give their input on how each of the "Community Mental Health Needs" were expressed in their specific ethnic or social groups and second, suggest strategies that would be most effective in the context of their community. Real-time translation for non-English speakers was offered at each of these meetings.

In order to illicit information from individuals within specific underserved groups who felt more comfortable in a smaller setting, 25 smaller Focus Group Discussions of twenty or fewer people were held throughout the County amongst a variety of populations (shown in Table 1). For example, there were two focus groups where transition age youth (TAY) provided input on the needs of their community. More information about the focus groups is shown in Table 1.

Additionally, information was obtained from underserved communities through the completion of the PEI Community Survey. This survey was available in different languages and completed by 1,083 individuals.

Of the more than 1,000 individuals that participated in the PEI Community Input Phase, approximately 130 (12%) identified as Latinos, 110 (10%) identified as Asian/Pacific Islanders (API), 30 (3%) as Native Americans and 95 (9%) identified as multi-racial or other. The participants in this phase included roughly 466 (43%) individuals that identified as providers or other staff from CBOs, 238 (22%) that identified as family members of consumers, 195 (18%) that identified as being consumers, 43 (4%) that identified as teachers, 43 (4%) that identified as guardians or foster parents, and 293 (27%) that identified as other members of the community.

Figure 1. Illustration of the PEI Planning Process

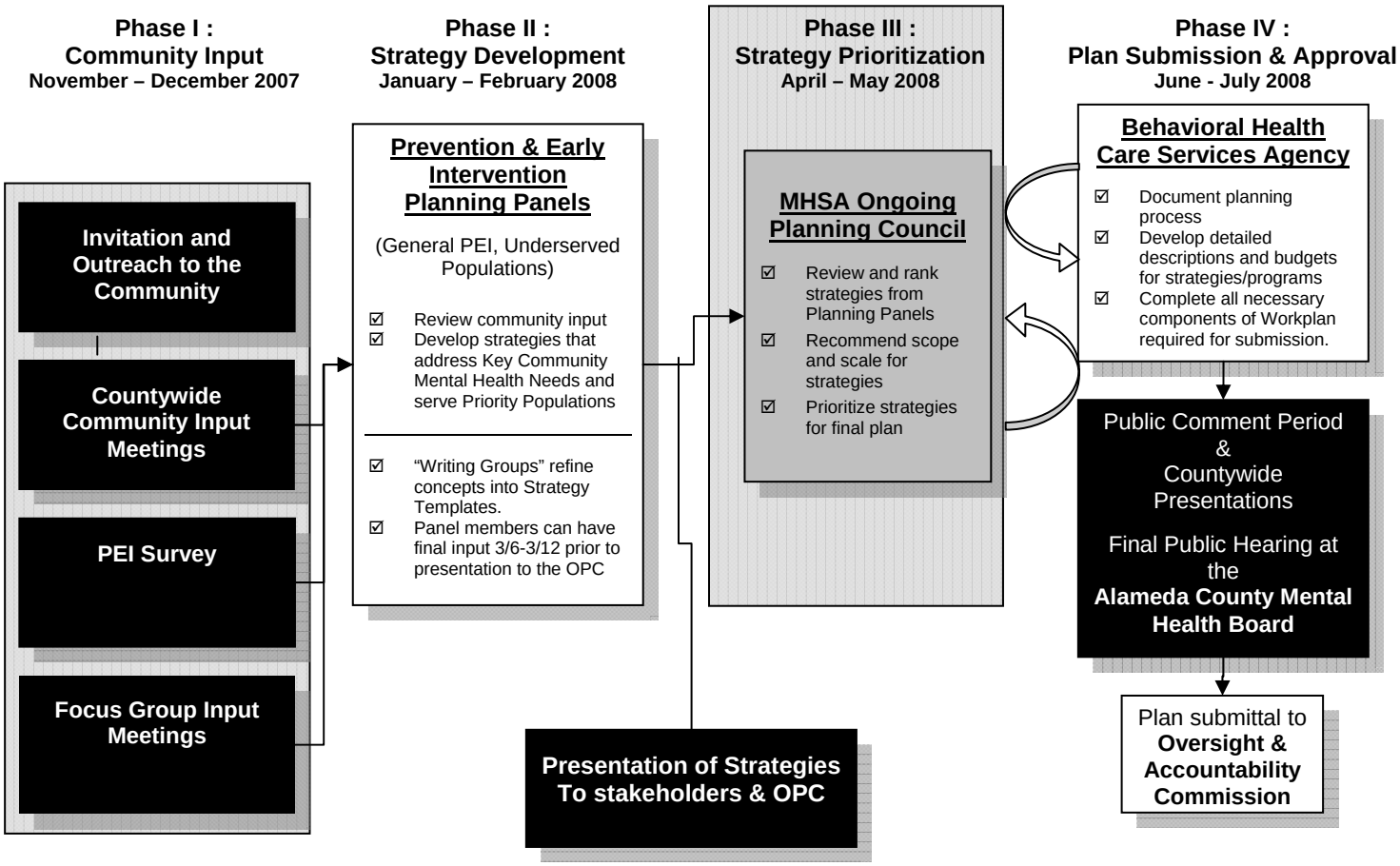

Figure 2. Brochure to Invite Stakeholder Participation

The Priority Populations to be served by Prevention & Early Intervention Funds:

Underserved Cultural Populations

Individuals Experiencing Onset of Serious Psychiatric Illness

Children/Youth in Stressed Families

Trauma-Exposed Individuals

Children/Youth at Risk for School Failure

Children/Youth at Risk of/or Experiencing Juvenile Justice Involvement

2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

Mental Health Service Act (Proposition 63)

Prevention & Early Intervention

Planning

2007-2008

You are invited to share your ideas and help design new programs that will address key community mental health needs:

- **Disparities in Access to Mental Health Services**
- **Psycho-Social Impact of Trauma**
- **At-Risk Children, Youth and Young Adult Populations**
- **Stigma and Discrimination**
- **Suicide Risk**

Prevention Programs involve reducing risk factors or stressors, building protective factors and skills, and increasing support. Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances.

Early Intervention Programs are directed toward individuals and families for whom a short-duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems or concerns thereby avoiding the need for more extensive mental health treatment or services; or to prevent a mental health problem from getting worse.

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PREVENTION AND EARLY INTERVENTION PLANNING

share

AT ONE OF OUR
COMMUNITY INPUT MEETINGS

Tuesday, November 27, 2007 (4pm – 6pm)
Eastmont Branch Library (in Eastmont Town Center)
7200 Bancroft Ave, Suite 211 (Oakland, CA)

Wednesday, November 28, 2007 (4pm – 6pm)
Taylor Memorial Church – Harris Hall
1188-12th Street (Oakland, CA)

Thursday, November 29, 2007 (4pm – 6pm)
Odd Fellows Hall – Banquet Room
1349 Hays Street (San Leandro, CA)

Monday, December 3, 2007 (4pm – 6pm)
Alameda County Conference Center
Oakland Room
125-12th Street, Suite 400 (Oakland, CA)

Tuesday, December 4, 2007 (4pm – 6pm)
Livermore Public Library – Community Rooms A & B
1188 South Livermore Avenue (Livermore, CA)

Wednesday, December 5, 2007 (4pm – 6pm)
Fremont Family Resource Center - Pacific Room
39155 Liberty Street (Fremont, CA)

Thursday, December 6, 2007 (4-6pm)
Alameda County Community Development Agency
224 Winton Avenue – Room 160 (Hayward, CA)

SYSTEM PARTNERS MEETING for County and other Public Service Agency Employees
Monday, December 10, 2007 (2-4pm)
Behavioral Health Care Services – Alameda Room
2000 Embarcadero Cove, Sui te 400 (Oakland, CA)

AT A SMALLER FOCUS GROUP MEETING
Contact us at 510-567-8133 if your or your organization would like to attend or host a Focus Group of twenty people or less.

Come to these meetings to learn about the state PEI guidelines and give input on what our local priorities should be.

1 community input

YOUR IDEAS ONLINE
Take the PEI Survey at
www.acbhcs.org

participate
WITH THE PREVENTION & EARLY INTERVENTION PLANNING PANEL

Planning Conference:
planned for the week of January 14

2 strategy development

Integration Conference:
planned for the week of February 11

Help develop strategies in response to the community's input by presenting your organization's or group's findings to the Panel or being a member of the Panel. Get more information at **www.acbhcs.org**

Reports for the Panel must be submitted by December 14, 2007. Applications for Panel membership are due on November 30, 2007.

attend
MENTAL HEALTH SERVICES ACT ONGOING PLANNING COUNCIL MEETINGS IN FEBRUARY & MARCH

3 strategy prioritization

Listen to the Council's discussions about prioritizing strategies and give your opinion during the public comment portion of each meeting.

Meeting times and agendas are posted at: www.acbhcs.org/MHSA/OPC/Meeting.htm

review
THE FINAL PLAN AND GIVE YOUR INPUT

The public comment period is planned for April. The final public hearing will be held at the Alameda County Mental Health Board Meeting planned for May 12, 2008.

Copies of the final plan will be available at our website, our offices or upon request by calling 510-383-1704.

4 plan submission and approval

ALAMEDA COUNTY Behavioral Health Care Services

For more information contact: mhsa@acbhcs.org
or call: (510) 383 - 1704
For more information on the PEI guidelines visit:
www.dmh.ca.gov/mhsa/

A Department of Alameda County Health Care Service Agency

with us

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Table 1. Focus Group Discussions

Meeting Date	Focus Group Population	Hosting Organization
November 13, 2007	Parents of At-Risk Teens	City of Livermore
November 13, 2007	Spanish-speaking parents of At-Risk Teens	City of Livermore
November 14, 2007	Peer health educators	East Bay Asian Youth Center / Oakland High Wellness Center
November 15, 2007	Youth Mentors to Middle / Elementary School students	East Bay Asian Youth Center
November 16, 2007	Foster Youth Providers	Foster Youth Alliance
November 20, 2007	Lesbian, gay, bisexual, transgender, queer, questioning and intersexed (LGBTQQI) Youth	Project Eden
November 26, 2007	Mental Health Consumers	Alameda County Pool of Consumer Champions (ACPOCC) Tenant Support Program
November 26, 2007	Latino, Spanish-speaking, Mental Health Consumers	ACPOCC
November 27, 2007	African American parents of consumers	African American Mental Health Support
November 28, 2007	Clinical psychologists working with South Asian population	The Hume Center
November 29, 2007	Homeless Senior mental health consumers	St. Mary's Center
December 4, 2007	County-Wide Police Officers	Police Department
December 5, 2007	Spanish-speaking parents	Hawthorne Family Resource Center
December 6, 2007	Berkeley MHSA Steering Committee	City of Berkeley Health & Human Services
December 6, 2007	Afghan men's support group	Afghan Coalition
December 7, 2007	Families of Consumers	Children's Hospital, Center for the Vulnerable Child
December 7, 2007	Multi-cultural youth	Youth Uprising
December 9, 2007	African American holistic health providers & community health conductors	Health Conductors/Holistic Health Providers
December 11, 2007	Native American adults & youth	Native American Health Center
December 12, 2007	Homeless adult consumers	Peers Envisioning and Engaging in Recovery Services (PEERS)
December 12, 2007	Deaf community	St. Joseph Center for the Deaf
December 12, 2007	School-Based mental health providers	Castro Valley USD - Special Ed Services
December 13, 2007	Mental health consumers	Coalition for Alternatives in MH - Berkeley
December 13, 2007	Providers & Consumers	Berkeley/Albany MH Commission
December 14, 2007	Older Adults	Fremont Adult Day Center

In addition, a variety of organizations including those serving underserved ethnic (API, Latino, Native American, South Asian and Afghan) and age groups (children, youth, TAY, and older adults) provided information through Community Reports.

Prior to the PEI Community Input Process, three groups were convened by ACBHCS to study priority issues identified through CSS. Those three issues were: the needs of underserved ethnic and language populations; programs to address early intervention at the onset of psychosis and the needs identified by mental health consumers. Planning grants were secured for each of the identified UELP groups to support their development of individual community reports. Each of these UELP groups, as well as the Alameda County Study Group on Early Intervention at the Onset of Psychosis, and the Alameda County Pool of Consumer Champions (ACPOCC) was successful in submitting a Community Report.

Table 2. PEI Community Reports submitted during Community Input Process

Community Report Topic	Organization
Afghan Community experiences disparities in access to Mental Health services and stigma and discrimination.	Afghan Coalition
Underserved and unserved Asian Pacific Islander (API) populations experience disparities in access to Mental Health services.	Asian Pacific Psychological Services & Asian Community Mental Health Services
• Survey of mental health needs in the Latino community of Alameda County. • Focus Groups conducted with Latinos in Northern Alameda County on mental health needs.	Casa del Sol/ La Clinica del la Raza
Needs assessment for Latino community and South Asian community in South and East County,	Portia Bell Hume Behavioral Health & Training Center
Integrated Primary Care & Behavioral Health Services for Latinos: A Blueprint and Research Agenda.	La Clinica del la Raza (Federally Qualified Health Clinic)
Integration of Mental Health and Primary Care services.	• Lifelong Medical Care • Safety Net Collaboration • Alameda Health Consortium
Native American community experience disparities in access to Mental Health services.	Native American Health Center
Recommended PEI strategies for Children, Preschool and Elementary School.	• Alameda County Early Childhood Mental Health Planning Committee • Alameda County Children's Advisory Committee • Alameda County Health Care Services Agency, School Health Services Coalition • Alameda County Public Health Department, Improving Pregnancy Outcomes Program
Developing a Mentor Model in a Local School District.	Alameda County Sheriff's Office, Youth & Family Services Bureau

Recommendations for PEI strategies for Children and Youth.	• Center for the Vulnerable Child • Children & Family Services Network of Alameda County • Fred Finch Youth Center
California Comprehensive Study of the Juvenile Justice System.	Huskey Tracking Committee
Community Engagement for Integral Health and Development of At-Risk Youth.	Seneca Center and Niroga Institute
Recommend a Mobile Response Team program for children and youth.	Seneca Center
Needs assessment and recommendations for PEI strategies for children and youth in Alameda County.	Safe Passages
Needs assessment and recommendations for PEI strategies for Transitional Age Youth.	ACBHCS Study Group on Early Intervention at the Onset of Psychosis
• Report on the priority of Discrimination and Stigma Reduction. • Social Inclusion Survey.	Alameda County Pool of Consumer Champions (ACPOCC)/ Peers Envisioning and Engaging in Recovery Services (PEERS)/ Alameda County Network of Mental Health Clients
Suicide prevention for older adults.	Institute On Aging - Center for Elderly Suicide Prevention and Grief Related Services

The results of the PEI Community Input Phase were presented at a Two-Day Conference in January 2008 to the PEI Planning Panels and other interested parties such as, ACBHCS Staff and the public. This meeting also served as a kick-off for the next planning phase.

Planning Phase II: Strategy Development

The MHSA Planning Team received and processed applications for the PEI Planning Panels in order to formulate a diverse group. The MHSA Project Management Team reviewed all applications and identified individuals that: (1) appropriately represented the DMH Required and Recommended Sectors for participation, (2) represented a broad range of ethnic diversity, and (3) represented the distinct geographic regions of the County. Of the two Panels, one focused on the needs of the general population and the other focused on the specific needs of unserved/underserved ethnic and language populations. Each Planning Panel developed its own structure for decision making and identifying priority strategies within the allocated timeframe.

For example, at its first meeting the General Planning Panel decided to split into four age-specific workgroups, each of which was charged with developing one to three priority strategies. The workgroup structure was similar to that used in the CSS Planning Process and included workgroups specific to adults and underserved age-groups such as children and youth, transition-age youth (TAY) and older adults.

Underserved Ethnic and Language Populations (UELP) groups were identified as a priority for PEI funding, as they were not targeted by CSS due to its focus on individuals diagnosed with Serious Mental Illness (SMI) and the stigma in many of

those communities towards conventional mental health screening, assessment and treatment. Prior to launch of the Planning Panels, an UELP Planning Group was convened by ACBHCS and given one-time funds to study the needs of UELP groups and present their findings and recommendations in a community report with the purpose of informing the PEI Planning Panels in the development of PEI strategies. The UELP Planning Panel met as a team to identify broad strategies that cut-across each of the target ethnic groups. The resulting strategies consisted of three main components: (1) Outreach & Education, (2) Mental Health Consultation, and (3) Cultural Wellness Practices. These broad PEI strategies were then adapted to address the specific needs of each underserved ethnic and languages population.

Real time translation was available to non-English speakers at each Planning Panel meeting. To meet the needs of consumers and family members, stipends were provided for their time. Since the Planning Panel meetings took place in the northern region of the County, transportation reimbursements were given to those who lived in South or East County.

The Planning Panels reviewed, analyzed and discussed the results of the PEI Community Input Phase and worked to identify and write priority local strategies based on participants' expertise of existing community capacity and strengths. Individuals from each Panel were elected into writing workgroups. These writing workgroups presented strategy narrative and program descriptions to the larger Planning Panels for their feedback. All writers received extensive technical assistance from ACBHCS staff while drafting the strategies. Additionally, the UELP Panel was assisted by a consultant from the University of California, Berkeley who is considered an expert in the field of program development. All members of the Planning Panels were asked to provide multiple rounds of feedback to ensure that the writing accurately reflected the group discussions and recommendations.

There were 59 diverse individuals that participated in the PEI Planning Panels. The Planning Panel members included 12 Latinos (20%), eight (14%) APIs, three (5%) Native Americans and six (10%) that identified as being from other groups including South Asian and multi-racial. Table 3 provides more detail about the planning panel composition.

Table 3. Planning Panel Composition

California DMH Required Sectors	General Planning Panel	Underserved Ethnic & Language Populations Planning Panel
Underserved Communities Community based organizations representing Native American, African American, Hispanic/Latino, Asian/Pacific Islander (API), Refugee, Lesbian/Gay/Bisexual/Transgender, and other underserved/un-served communities	1. Seprieono Locario (Native American Health Center) 2. Fawada Mojaddidi (Portia Bella) 3. Jan Garrett (Center for Independent Living)	1. Christopher Cara (Filipinos for Affirmative Action) 2. Luzi Camarillo (Portia Bella Behavioral Healthcare) 3. Leticia Escalara (Center for Independent Living) 4. Ahmad Zamani (Afghan Care) 5. Gigi Crowder (ACBHCS Ethnic Services Manager)
Education County offices of education, school districts, Special Education Local Plan Areas, school-based health centers, universities, community colleges, adult education, First 5 Commissions	4. Aaron Chidester (Unite 4 Life) 5. Angie Garling (Alameda County Childcare Planning Council) 6. Patricia Spencer (Alameda Parent Teacher Association) 7. Barbara McClung (Oakland Unified School District)	6. Suzanne Fares Lawless (Tri-Valley Community Foundation) 7. Scott Osborn (Seneca Center)
Individuals with Serious Mental Illness and/or their Families Client and family member organizations	8. Maria Corral (Alameda County Pool of Consumer Champions - ACPOCC) 9. Adrianne Desantis (ACPOCC) 10. Claudia Sanders (Bay Area Community Services) 11. Juan Gonzales (ACPOCC) 12. Laura Foster (Emergency Room Physician) 13. Lanita Mims (Family Partner) 14. Liz Rebensdorf (National Alliance on Mental Illness) 15. Julie Testa (Family Partner) 16. Darnel Levingston (Howie Harp)	8. Maria Torres (ACPOCC) 9. Sabirah Mustafa (ACPOCC) 10. Madlynn Johnson (Alameda County Network of Mental Health Clients) 11. Gerardo Vidal Castaneda (Casa del Sol) 12. Olga Zepeda (Horizons Family Counseling) 13. Melba Davis (Consumer)
Provider of Mental Health Services Behavioral health services provider organizations	17. Rochelle Collins (Project Eden) 18. Jodie Langs (Alameda County Foster Youth Alliance) 19. Gerald Michaels (ACBHCS) 20. Kent Ellsworth (Bay Area Community Services)	14. Joty Sikand (The Hume Center) 15. Beatrice Lee (Asian Pacific Psychological Services) 16. Leslie Preston (La Clinica) 17. Janet King (Native American Health Center) 18. Marcella Sabin (Berkeley Mental Health) 19. John Fong (Asian Community Mental Health Services) 20. Rona Popal (Afghan Coalition) 21. Margie Padilla (ACBHCS) 22. Ella Wolfgramm, Consumer
Health Health clinics, public health, primary health care settings, specialist in mental health services, specialist in older adult care health services, Native American Health Centers, community health, alcohol and drug treatment centers, regional centers, emergency services, maternal child and adolescent health services	21. Susan Contreras (Alameda County Public Health) 22. Irene Casanova (Tiburcio Vasquez Health Center)	23. Eva Garcia (AC Public Health) 24. Jen Lee (Asian Health Services)

California DMH Recommended Sectors	General Planning Panel	Underserved Ethnic & Language Populations Planning Panel
Social Services Child and family welfare services, CalWORKs, child protective services, home and community care, disability services, adult protective services	23. Sarah Hipolito (Alameda County Social Services Agency) 24. Andrea Ford (Alameda County Social Services Agency)	25. Gail Hart (Hart to Heart) 26. Chris Shaw (Alameda County Social Services Agency) 27. Fiona Branagh (ACBHCS) 28. Eowyn Gorman (Family Service Community Counseling) 22. Mary Norris (American Indian Child Resource Center
Law Enforcement County criminal justice, courts, juvenile and adult probation offices, judges and public defenders, sheriff/police	25. Eric Gomes (Alameda County Probation) 26. John Beard (Youth & Family Services, Hayward Police)	29. Idabelle Fosse (Safe Passages) 23. Norm Santos (Alameda County Probation)
Community Family Resource Centers Multipurpose family resource centers, faith centers, arts, sports, youth clubs/centers, parks and recreation, homeless shelters, senior centers, refugee assistance centers	27. May Cheng (Davis Street Family Resource Center) 28. Pier Schwartz (St. Mary's Center)	24. Mary Norris (American Indian Child Resource Center) 25. Eowyn Gorman (Family Service Community Counseling)
Employment Public and private sector workplaces, employee unions, occupational rehabilitation settings, employment centers, Work Force Investment Boards	29. Kevin Williams (Berkeley Youth Alternatives)	

Planning Phase III: Strategy Prioritization

The Ongoing Planning Council (OPC) is the local MHSA stakeholder group that was formed during the CSS process to prioritize local strategies and make strategy and funding recommendations to ACBHCS. This group assumed the same function during the PEI process. Additionally, the OPC worked to review and prioritize the strategies developed by the Planning Panels to ensure that funding decisions were driven by the combined needs and priorities of a diverse cross-section of individuals. By looking at state planning mandates and local priorities, the OPC developed a review tool to help them develop their initial scores of the PEI Strategies. The OPC's process consisted of multiple rounds of prioritization that included both individual and aggregated scoring, as well as a series of in-depth small group and council-wide discussions about the different strategies and overall plan. The OPC also worked with the MHSA Project Management Team and MHSA Planning Staff to assign further programming details and draft budgets to these prioritized strategies. By June 2008, the OPC had identified eight priority projects to be funded through the available PEI resources. The OPC also provided ACBHCS Administration direction on where additional funding should be assigned should Alameda County receive additional PEI funds in the future. With additional funding, the OPC directed that a general primary care integration strategy should be funded without reducing funding for any of the other projects. The OPC also noted that additional funds should be assigned to projects 5 and 6 in order to address concerns that these projects may be underfunded. Recently, the California State Department of Mental Health has announced that it will be releasing additional funds for PEI statewide. As soon as Alameda County receives confirmation of the amount of any additional allocation and the specific guidelines about how this additional allocation must be spent,

ACBHCS will proceed in consideration of these and other projects consistent with the established planning process.

The goal of the OPC is to maintain a membership configuration of one-third consumers, one-third family member and one-third providers and other (not including members from the ACBHCS administration). During the time of their deliberations in March through June 2008, the composition of the group included seven Latinos, three APIs, one Native American and one Afghan American.

Table 4. Ongoing Planning Council Composition

Stakeholder Sector	Member		Affiliation/Position
Consumers	Ms. Khatera	Aslami	Alameda County Pool of Consumer Champions (ACPOCC)
	Mr. Juan	B. Gonzalez	ACPOCC
	Ms. Sheila	Jumping Bull	Native American Health Center
	Ms. Carol	Patterson	Berkeley Mental Health
	Ms. Shirley	Posey	ACPOCC
	Mr. John	Woodruff	ACPOCC
	Ms. Sally	Zinman	ACPOCC
	Ms. Andree	Reyes	Wellness, Recovery & Resiliency Resource Hub
Family Members	Ms. Patty	Espeseth	Eden Psych & Family Support
	Mr. Jerry	Fillingim	SEIU Local 1021
	Ms. Cynthia	Frankel	Alameda County Emergency Medical Services
	Ms. Leonila	Ponce	Horizons Family Counseling
	Ms. Alane	Friedrich	Mental Health Board
	Ms. Regina	Simpkins	ACPOCC
	Ms. Julie	Hawthorne	AB 3632 Case Management
	Ms. Ana	Rojas	Family Member
	Ms. Suzanne	Shenfil	City of Fremont
	Mr. David	Wu	Asian Community Mental Health Services
Providers of Mental Health Services	Ms. Paula	Barber	Center for Family Counseling
	Ms. Patricia	Barrera	Alameda Health Consortium
	Ms. Deborrah	Bremond	Mental Health Board
	Ms. Evelyn	Crespo	La Clinica de La Raza
	Mr. Rick	Crispino	Bonita House
	Mr. John	Fong	Asian Community Mental Health Services
	Mrs. Beatrice	Lee	Asian Pacific Psychological Services
	Rev. Barbara	Meyers	Mission Peak Congregation
	Dr. Tom	Powers	AC-CC Medical Association
	Ms. Jean	Prasher	City of Livermore
	Ms. Michelle	Starratt	Alameda County Housing & Community Development
	Ms. Karyn	Tribble	Berkeley Mental Health

Board of Supervisors	Ms. Sarah	Wilson	Staff to Supervisor Alice Lai-Bitker
	Mr. Seth	Kaplan	Staff to Supervisor Nate Miley
Alameda County Behavioral Health Care Services Administration, Operations	Mr. Peter	Alevizos	Director, Adult Services
	Ms. Michelle	Burns	Director, Transition Age Youth (TAY) Services
	Ms. Diana	Cunningham	Management Services
	Ms. Gigi	Crowder	Ethnic Services Manager
	Ms. Marlene	Gold	Finance Director
	Mr. Jay	Mahler	Consumer Relations Manager
	Ms. Barbara	Majak	Deputy Director
	Ms. Carolyn	Novosel	Director, Children & Youth Services
	Mr. Clint	Nix	Director, Older Adult Services
	Mr. Robert	Ratner	Housing Services
	Mr. Gary	Spicer	Director, Office of Management Services
	Ms. Marye	Thomas	Mental Health Director
	Mr. Jim	Hinson	Adult Service Teams

b. Provided opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language.

According to 2007 Census data, Alameda County has a population of over 1.45 million individuals. Alameda County is not only populous, but it is also geographically large and diverse.

The County is usually described in four regions; North, Central, South and East County. North County contains 42% of Alameda County's population. It consists of the cities of Alameda, Albany, Berkeley, Emeryville and Oakland, with a combined population of 627,483 individuals. Central County holds 23% of the entire county's population and is comprised of the cities of Hayward, San Leandro and unincorporated areas of Castro Valley, San Lorenzo, Cherryland, Ashland and Fairview with a combined population of 350,752 individuals. South County is home to 22% of the county's population and includes the cities of Fremont, Newark and Union City, with a combined population of 328,147 individuals. Lastly, East County holds 13% of the county population and is defined as the cities of Dublin, Livermore, Pleasanton and the unincorporated area of Sunol, with a total population of 195,538 residents.[1]

Alameda County is also comprised of diverse ethnic and racial populations: 829,275 (38%) White non-Hispanic individuals; 367,271 (26%) APIs; 311,889 Hispanic/Latinos; 199,667 (14%) Black/African American individuals; 51,009 (4%) Multi-Racial/Other individuals and 10,202 (1%) Native Americans. Additionally, twenty-seven percent of the population is born outside of the United States. Moreover, 37% of Alameda County's population over the age of five speaks a language other than English at home.[2]

In terms of age, there are roughly 348,529 children and youth age 0-17 years, 153,422 TAY age 18-25 years, 719,577 adults age 26-59 years, and 198,471 older adults age 65 years and over in Alameda County. Children and youth represent

[1] Census 2000.
[2] Census 2006.

roughly 25% of the total population in Alameda County, TAY represent 11%, adults represent 51%, and older adults represent 14% of the total County population.[3]

Planning Phase I: Community Input Phase

The PEI Community Input Phase engaged roughly 1,083 individuals from diverse ethnic, age and geographical backgrounds. The engagement process closely resembled Alameda County's demographics and attempted to represent the community at large. The Community Input Process engaged approximately 410 (38%) Caucasians, 305 (28%) African Americans, 130 (12%) Latinos, 110 (10%) APIs, 30 (3%) Native Americans, and 95 (9%) individuals that listed themselves as multiracial or other. In terms of age, there were approximately 45 (4%) youth under 18 years, 65 (6%) TAY from 18-25 years, 745 (69%) adults from 25-59 years and 230 (21%) older adults over 59 years. The process was also geographically diverse; the process engaged approximately 770 (70%) individuals from North County (Alameda, Albany, Berkeley, Emeryville, Oakland, and Piedmont), 185 (17%) from Central County (Castro Valley, Hayward, San Leandro, San Lorenzo, and Unincorporated Areas), 75 (7%) from South County (Fremont, Newark, and Union City), and 65 (6%) from East County (Dublin, Livermore, Pleasanton, and Sunol). In terms of gender, about 71% of the participants were female, 29% were male and 1% reported their gender as other. In addition, a variety of organizations, including those serving underserved ethnic (API, Latino, Native American, South Asian and Afghan) and age groups (children, youth, TAY, and older adults), provided information through Community Reports. Prior to the PEI Community Input Phase, an Early Intervention at the Onset of Psychosis Study Group was convened by ACBHCS and given one-time funds to study this issue and present their findings and recommendations to the Planning Panels through a Community Report. This Study Group noted that onset of psychosis is a particularly important issue for TAY.

Planning Phase II: Strategy Development

The PEI Planning Panels engaged 59 individuals in more detailed discussions about local priorities and strategy development. In terms of ethnicity, the Planning Panels engaged 20 (34%) Caucasians, 12 (20%) Latinos, 10 (17%) African Americans, eight (14%) APIs, three (5%) Native Americans, and six (10%) that listed themselves as being from other groups including South Asian and multiracial. Geographically the panel consisted of 35 (59%) participants from North County, 12 (20%) from Central County, seven (8%) from East County, and five (12%) from South County. A majority of the participants were adults, yet 32 said they were particularly interested in PEI for children and youth, 25 said that they were particularly interested in PEI for TAY, 33 said they were particularly interested in PEI for adults, and 21 said that they were particularly interested in PEI for older adults. In terms of gender, 75% of the Panel Members were female and 25% were male.

[3] Census 2000.

Planning Phase III: Strategy Prioritization

The OPC included 26 Whites non-Hispanic, seven Latinos, three APIs, one Native American, one Afghan American and six African Americans. Additionally, the OPC included representatives from all County regions and both genders. The OPC was comprised of participants with expertise across the age span.

c. Included outreach to clients with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate.

Alameda County ACBHCS assertively responded to the MHSA's mandate to involve consumers in all aspects of the MHSA. In the summer of 2006, a Consumer Relations Manager was hired. Within a year, through the efforts of the ACBHCS office, which itself hired additional consumer staff, the Alameda County Pool of Consumer Champions (ACPOCC), an active grass roots group of consumers geographically representing Alameda County, was born. From its inaugural Conference in May 2007, the ACPOCC has grown to close to 200 consumers strong. The ACPOCC empowers its members on their journey toward recovery, keeping them informed through trainings and teaching them leadership and advocacy skills. The ACPOCC also provides an essential vehicle for the consumer voice in all MHSA planning and implementation in the County, with members that have actively participated in each phase of the PEI Planning Process.

In Planning Phases II and III, all consumers and family members that did not receive pay through another organization were given stipends for each meeting they attended. As most of the Phase II and III meetings were held in North County, transportation reimbursements were also provided for consumers and family members traveling long distances from South and East County.

Planning Phase I: Community Input Phase

The PEI Community Input Phase engaged roughly 195 individuals that identified as consumers and roughly 240 individuals identified as family members.

Planning Phase II: Strategy Development

Of the 59 individuals on the PEI Planning Panels, seven (12%) participants identified themselves as consumers, and eleven (19%) participants identified themselves as family members. In addition, MHSA Planning Staff provided optional pre-meeting orientation sessions that were specifically geared towards supporting consumers and family members to be active participants in the Planning Panels. The pre-meeting orientation sessions included a review of the agenda and any other key documents that would be shared at the meeting, such as state guidelines The sessions also provided an opportunity to ask questions and group brainstorm about successful participation in the upcoming meeting. ACBHCS Staff also provided more intensive one-on-one assistance when needed.

Planning Phase III: Strategy Prioritization

Of the members of the OPC, eight identified themselves as consumers and five identified themselves as family members.

3. Explain how the county ensured that the Community Program Planning Process included the following required stakeholders and training:

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:

- ***Individuals with serious mental illness and/or serious emotional disturbance and/or their families***
- ***Providers of mental health and/or related services such as physical health care and/or social services***
- ***Educators and/or representatives of education***
- ***Representatives of law enforcement***
- ***Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families***

Please refer to Question 2, particularly Table 3. Planning Panel Composition and Table 4. Ongoing Planning Council Composition, above which includes detailed information about the diverse stakeholders involved in the process.

b. Training for county staff and stakeholders participating in the Community Program Planning Process.

Training and orientation on the PEI planning guidelines were provided to stakeholders at each Planning Phase. The broad community received a brief overview of the planning guidelines during each of the eight large Community Input Meetings and the 25 Focus Group Discussions. The members of the two Planning Panels received a half-day overview of the guidelines in their orientation to the Panel. Members of the OPC had training sessions over the course of two meetings in January and February in preparation for review the PEI strategies. In these meetings, the OPC was provided with information about the state and local mandates and the purpose of PEI which led to in-depth discussions and the development of a strategy review scoring tool. Further OPC meetings provided orientation to and discussion of the strategies that were developed by the PEI Planning Panels. Two special voluntary meetings for consumers and family members were held in January and February to address their specific needs and to promote their full participation at all these events.

County staff new to MHSA planning received more intensive orientation and support from those that had participated in the previous planning processes for Community Services and Supports. Ongoing training was also provided through weekly and ad-hoc staff meetings regarding the PEI Planning Process.

4. Provide a summary of the effectiveness of the process by addressing the following aspects:

a. The lessons learned from the CSS process and how these were applied in the PEI process.

Addressing disparities in mental health services to ethnic communities

The CSS Planning Process did not produce many programs that will reduce disparities in service to individuals from underserved ethnic and language communities, specifically those that have the lowest utilization rate when compared to prevalence, such as Latinos and Asian/Pacific Islanders (APIs). In reviewing the CSS Planning Process, there were two main reasons for this. First, the low numbers of Latinos and APIs amongst the homeless population, which was the emphasis of the Full Service Partnerships, which represented half of the allocated CSS funds. Second, CSS funding required that programs target individuals with SED/SMI and the underlying stigma of mental illness in those communities inhibits proper identification and diagnosis of SED/SMI. Since PEI funding did not include the Full Service Partnership model or the SED/SMI requirement, ACBHCS developed a needs assessments in the major ethnic communities in anticipation of the PEI Planning Process. ACBHCS contracted with organizations serving the Latino, API, Afghan, South Asian and Native American populations to conduct a needs assessment and recommend strategies that were consistent with the PEI definitions and guidelines.

Empowering consumers to become involved in planning from the beginning

Inclusion of the consumer voice in CSS planning was critical to ensuring the successful design of programs; ACBHCS wanted to build on the immense effort in recruiting and engaging consumers by institutionalizing their increased participation throughout the system. In the summer of 2006, a Consumer Relations Manager was hired and within a year began the Alameda County Pool of Consumer Champions (ACPOCC). The ACPOCC is an active grass roots group of consumers geographically representing Alameda County. From its inaugural Conference in May 2007, the ACPOCC has grown to close to 200 consumers, with approximately 70% of the group comprised of ethnically diverse and underserved/inappropriately served individuals, serving on eight ACPOCC activity and policy Committees. The ACPOCC empowers its members on their journey toward recovery, keeping them informed through trainings and teaching them leadership and advocacy skills. Moreover, it provides an essential vehicle for the consumer voice in all MHSA planning and implementation in the County. Nine ACPOCC members currently sit on the Ongoing Planning Council, Alameda County's MHSA stakeholder advisory group. ACPOCC members also have significant participation in other non-MHSA county committees, such as Cultural Diversity, Spirituality, Criminal Justice and Dual Diagnosis.

In collaboration with ACBHCS and Peers Envisioning and Engaging in Recovery Services (PEERS), a consumer-run agency in Alameda County, ACPOCC sponsored "Breaking the Ties that Bind; Challenging Stigma and Discrimination." This Conference brought together 400 individuals such as experts from the state,

consumers from adjoining counties, and Alameda County consumers, providers, administration and legislators to discuss the issue of stigma and discrimination. At this Conference and in a follow up mailer, a survey about stigma and discrimination was distributed. Consumers then developed a Stigma and Discrimination Reduction strategy from the results of the survey as well as other consumer sponsored meetings, in person and via e-mail and phone. This strategy was submitted to the County to be considered for its PEI Plan. Parallel to this process, consumers were actively involved in the County's PEI stakeholder process, by completing the County PEI survey and attending the stakeholder meetings across the County in critical mass. After applying for membership, eight ACPOCC members were appointed to the PEI Planning Panels which were responsible for the development of the PEI Strategies. Through this collaborative process, a multi-faceted Stigma and Discrimination Reduction Project has been approved by the County as part of its Draft PEI Plan.

Understanding the difference between "strategies" and "programs"

During the CSS Planning Process, much of the program design was completed by the four Age-Specific Planning Panels and twelve workgroups. The program design entailed the development of staffing configurations and full budgets, including revenue estimates. As the CSS Planning Panels and Workgroups had membership from an array of stakeholders including ACBHCS staff, consumers, family members and providers, an equally wide range of approaches to budgeting were used rather than a common set of principles. As a result, much of the panels' work required significant revisions in order to be in line with realistic expectations for staffing levels and revenue. Thus the budget reformulation process created unanticipated delays in implementation.

In the PEI process, Paneling Panels were instructed to develop only "strategies," broad descriptions of interventions that serve a specific target population, and work towards a specific outcome. After prioritizing which strategies were likely to be implemented, ACBHCS staff conducted exhaustive research of both local and out-of-County comparison programs in order to develop realistic budgets and create full "programs." The recommended program design, staffing and budgets were then reviewed for consistency by MHSA Staff in collaboration with members of the ACBHCS Administration during the weekly System of Care Director Meetings. This process ensured a uniform method of budgeting, which will help ensure a smooth make implementation of the programs.

b. Measures of success that outreach efforts produced an inclusive and effective community program planning process with participation by individuals who are part of the PEI priority populations, including Transition Age Youth.

Engagement of diverse stakeholders

As described above, a large number of diverse stakeholders, including TAY and their advocates, were involved in all three components of the community planning process. Many of the stakeholders were from underserved and inappropriately served groups. Additionally, participants included advocates from all age-groups and

all geographic regions of the County. Many of the participants were consumers and family members.

Prior to the PEI Community Input Process, three groups were convened by ACBHCS to study specific priority issues identified through CSS. Those three issues were: the needs of underserved ethnic and language populations; programs to address early intervention at the onset of psychosis and the needs identified by mental health consumers. Each of these groups was successful in submitting a community report and laying the groundwork for a strategy that was identified as a priority for local funding by the OPC.

Positive feedback through Planning Panel Satisfaction Survey

ACBHCS also conducted a process satisfaction survey with the individuals that participated in the PEI Planning Panels. Participants were asked to rate their satisfaction on a scale of "Strongly Agree=5" to "Strongly Disagree=1." As shown in Table 5, the average scores were high indicating a high level of satisfaction with the process for both consumers and all respondents.

Table 5. Results from Planning Panel Evaluation

	Consumers Only	All Respondents
Statement 1: I feel my voice was heard and valued in this process	4.1	4.3
Statement 2: I feel that my participation has helped to improve PEI services in Alameda County.	3.9	4.1
Statement 3: I feel that the PEI strategies developed by the panels are reflective of community needs.	4.1	4.2

Positive feedback through public comment

Alameda County also gathered positive feedback from diverse stakeholders during the public comment portion of the Phase IV of the plan. Individuals from many communities spoke about their appreciation of the planning process, specific strategies or both. Fifteen percent of the public comments were in appreciation of the PEI process, strategies or both.

The following quotes are examples of those comments:

- A San Leandro resident said: "[I am] grateful for the process, and hard work."
- A member of the Native American community said, "Thank you. [We] enjoyed the process over last several years. [We are] proud of fact that there is Native American component and we're very appreciative. The community thanks you for including us in this process."
- A youth advocate stated the following: "Thanks. We were pleased to see adolescent health included, statewide only about 2% of county funded mental health programs are funded for adolescent services, so Alameda County can teach a lot to the state. We are happy to see services for TAY [transition-age

youth], most at risk for suicide and co-occurring disorders; also school-based services; and inclusion of peer development and youth-inclusion models, so thank you again. Hope that other counties can learn from your plan."

- A consumer advocate shared the following: "I want to congratulate this county, because it was extremely inclusive of all stakeholder groups. We used to hear a lot of criticism at the state level but I don't think anyone will be complaining about Alameda County. Many counties don't even go through this comment process, they just have the board hearing at the end. You go beyond that. Of course dear to my heart is Project 4 and I'm so glad it's in the County's plan and funded at this level, it is comprehensive with many components and in the plan is written internalized and external discrimination, all of which are essential for recovery and mental health. You'll hear more of that. It's very important that it be consumer led, important that it be in partnership with all other stakeholders in the county."

5. Provide the following information about the required county public hearing:

a. The date of the public hearing:

The 30-day review period ended with an official public hearing conducted by the Alameda County Mental Health Board:

Monday, July 14, 2008, 12:00pm-2:00pm
First Five Training Center
1100 San Leandro Boulevard - Suite 130
San Leandro, CA

b. A description of how the PEI Component of the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any other interested parties who requested it.

The draft plan and executive summary of the draft plan were made available on the ACBHCS website with copies distributed at the main public libraries in each of the large cities throughout the County.

Table 6. PEI Plan Distribution to Public Libraries in Alameda County

City	Mailing Address	County Regions
Berkeley	2090 Kittridge Street, Berkeley, CA	North
Dublin	200 Civic Plaza, Dublin, CA	East
Fremont	2400 Stevenson Blvd., Fremont, CA	South
Hayward	835 C St., Hayward, CA	Central
Livermore	1188 So. Livermore Ave., Livermore, CA	East
Newark	6300 Civic Terrace Ave., Newark, CA	South
Oakland	125 14th St, Oakland, CA	North
Pleasanton	400 Old Bernal Ave., Pleasanton, CA	East
San Leandro	300 Estudillo Ave., San Leandro, CA	Central
Union City	34007 Alvarado-Niles Road, Union City, CA	Central

Postcards announcing the availability of the draft plan were mailed to all of the ACBHCS service providers and the MHSA mailing list, which included key stakeholders such as members of the Planning Panels and OPC. Notice was also posted in eight newspapers throughout the County including the major ethnic language papers.

A four-page Executive Summary was prepared and translated into the County's threshold languages: Spanish, Chinese, Vietnamese and Farsi. These translated versions were also posted on the website and made available through local libraries.

Five meetings were organized by ACBHCS and hosted by the Alameda County Mental Health Board during the 30-day review period in each Supervisorial district of the County in order to ensure that individuals throughout the County could ask questions about the plan as well as provide their comments in person. The agenda of each meeting included a brief presentation of the draft plan, a question and answer session and a long public comment period. Real-time translation was available at any given meeting upon request. Individuals could also submit their written comments by email as outlined in the postcard and the executive summary of the plan. A total of 151 individuals were active during Phase IV. Individuals engaged by attending the meetings, providing written and spoken comment or both. 106 individuals attended the public comment meetings; eight individuals emailed feedback; and 37 attended the final Mental Health Board meeting.

Monday June 23, 2008 (Supervisorial District 2), 4:00pm-6:00pm
Alameda County Community Development Agency
224 W. Winton Avenue - Room 160
Hayward, CA

Tuesday June 24, 2008 (Supervisorial District 3), 3:00pm-5:00pm
First Five Training Center
1100 San Leandro Boulevard - Suite 130
San Leandro, CA

Wednesday June 25, 2008 (Supervisorial District 4), 3:00pm-5:00pm
Wellness Center - Eastmont Mall
6955 Foothill Boulevard - Maxwell & Sobrante Rooms Oakland, CA

Thursday, June 26, 2008 (Supervisorial District 1), 4:00pm-6:00pm
Livermore Public Library
1188 South Livermore Avenue - Community Room A & B
Livermore, CA

Monday June 30, 2008 (Supervisorial District 5), 4:00pm-6:00pm
West Oakland Public Library Branch
1801 Adeline Street - Multi-Purpose Room
Oakland, CA

c. A summary and analysis of any substantive recommendations for revisions.

Table 7 displays an overview of the substantive public comments received during the public hearings and the ACBHCS response to each substantive theme or topic of interest. Substantive comments were defined as suggestions that would result in a concrete change in funding or program design. Please note that as there is overlap in the populations being addressed by these projects and that costs vary depending on the nature of a particular intervention. As such, the budgets are not meant to be proportional to a particular age or ethnic group's percentage of the total County population. **It is also important to note that the portfolio of PEI projects is not meant to stand alone; it is meant to complement and expand the network of existing local programs and the new programs that are now being developed through other MHSA funding streams, including Community Services and Supports (CSS) and Workforce Education and Training (WE&T).**

Recently, the California State Department of Mental Health has announced that it plans to release additional funds for PEI. As soon as Alameda County receives confirmation of the additional allocation amount and the specific guidelines about how this additional allocation must be spent, ACBHCS will proceed with considering these and other projects consistent with the established planning process.

Table 7. Summary of ACBHCS Responses to Substantive Public Comment

Topic A. Services for Children, Youth and Transition-Age Youth	
Public Comment	Response
'If there is any increase in funding I highly, highly urge the committee to put more funding in 0-5 services.' – Theme expressed by 10 individuals	This budget was reviewed by the Ongoing Planning Council (OPC) and deemed acceptable for the population. The actual operating budget for Project 1A is higher than shown, roughly $267,200, due to anticipated Medi-Cal revenues of $45,432 per year. Additionally, over $2 million dollars has been allocated to specific underserved ethnic populations that will serve individuals of all ages. These projects incorporate culturally based wellness practices to all ages, including children ages 0-5 and their families. Project 4 will also provide PEI services to families with young children.
'I would like to see something in [the plan] about training folks around early childhood mental health.' – Theme expressed by one individual	Project 1A focuses on training school staff and parents on early childhood mental health.
'I recommend you add "Parent Project" to [the plan].' – Theme expressed by one individual	The Parent Project has been added to the list of potential curriculums to be used in Projects 1B and 1C.
'I feel there should be more help with bipolar disorder teenagers' – Theme expressed by one individual	Alameda County provides mental health services to distressed youth with bipolar disorder and other serious mental illness (SMI) countywide through Medi-Cal's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and other funding sources. Project 2 will also provide additional support for bipolar teenagers experiencing onset of first psychosis.
'Concerned that full fidelity to the Portland Identification and Early Referral (PIER) Program, as specified in the [Project 2] Proposal, does not follow the services described on page 30 of the Proposal… Concerned that the staffing pattern and budget in the [Project 2] Proposal do not adequately allow for important program elements.' – Theme expressed by two individuals	The plan states that Project 2 is based on the PIER Program. It is expected that some differences will emerge through tailoring the model to Alameda County and due to lessons learned at both the national and local level. The staffing configuration for Project 2 was developed and reviewed by ACBHCS Administration and Operational Staff and deemed adequate for accomplishing the activities described. ACBHCS will continue to refine the program in the implementation phase.

Topic B. Mental Health-Primary Care Integration	
Public Comment	Response
'We recommend you fund two clinics for [broad] primary care integration to reach the full range of ethnic and age groups in any part of the County.' – Theme expressed by 12 individuals	This program was not included within the final prioritized list of projects that were recommended for funding by the Ongoing Planning Council (Stakeholder Group). The Ongoing Planning Council recommended that ACBHCS find additional funds to implement this program without reducing the budgets for the other prioritized projects. This will be a strong candidate for funding if additional funds become available. There are already mental health-primary care integration programs for older adults funded through PEI and Community Services and Supports (CSS). ACBHCS is also involved in multiple initiatives around primary care integration independent of MHSA funding.
Topic C. Ethnic-Specific Services	
Public Comment	Response
'There's no representation of the African American community to receive services. How did you outreach to the community to get their input and for them to have a voice in this process?' – Theme expressed by 12 individuals	As described on pages 7 and 8, African Americans participated in all phases of the PEI Planning Process. A program exclusively targeting the African American population was not developed by the PEI Planning Panels. The State mandated that the PEI projects target historically underserved populations. Because African Americans comprise 15% of the County population and receive 37% of our services, Alameda County identified African Americans as a possibly inappropriately served population, rather than an underserved population Although, the African American population has not received a specific project, the population will be served through various PEI projects. For example, it is anticipated that approximately 30% of the transition-age youth (TAY) receiving community-based treatment services under Project 2 will be African American. Additionally, African Americans will be served in Mental Health Consultation in Schools/Preschools and Stigma and Discrimination Reduction Campaign. In order to address the inappropriately served African American population, ACBHCS is using one-time PEI funds to launch a Study Group to identify best practices for addressing the needs of African Americans who are over-represented in the current mental health system. Outcomes of this analysis will be specific recommendations on how to better serve this population through the entire mental health system, including all MHSA components. It is expected that the Study Group's recommendations will be incorporated into the County's Integrated MHSA Plan which will be submitted to the state in Spring/Summer 2009.

'The Latino and API Strategies are way underfunded, when more money becomes available in future years, my request is to make sure they get more.' – Theme expressed by five individuals	As recommended by the OPC (Stakeholder Group), the budgets of these projects may be augmented if additional funds become available.
'Latinos need representation here [in East County]. Many are unable to get to services because of economy and cost. They can't get to the services, and transportation is not accessible to them.' – Theme expressed by 10 individuals	As currently written, Project 5 includes services to all four regions of the County. There will be Mental Health Promoter and Mental Health Specialist staff assigned to each county region for the Latino community.
'The Afghan Community is very underserved and we want to see a budget separate for the Afghan Community.' – Theme expressed by four individuals	A stand-alone Afghan program was not included in the final prioritized list of projects that were recommended for funding by the OPC (Stakeholder Group); a special emphasis on this population was supported by an increase in the original budget for Project 7. A separate Afghan project/budget may be created if additional funds become available.
Topic D. Implementation Process	
'I strongly encourage you to prioritize the needs of our youth out at the edge of the county when allocating funding under the MHSA.' – Theme expressed by 10 individuals	The proposed PEI portfolio specifies roughly $528,015 for children and youth at 3-6 elementary and middle schools (Project 1B), $289,546 for children and youth at 2 high schools (Project 1C), and $1,143,890 for TAY experiencing onset of first psychosis and SMI (Project 2), Specific locations for Project 1B and 1C will be determined in the procurement process. Project 2 will serve youth in all regions of the County.
'Ask that ACBHCS be careful in developing RFP's and monitoring accepted projects that service delivery is targeted towards children and youth consistent with the PEI guidelines around 51%..' – Theme expressed by two individuals	It is the intention of ACBHCS to ensure that providers for Projects 4, 5, 6, 7 and 8 demonstrate their ability to appropriately target and serve individuals in each of the MHSA age groups.
'Very important that we have [one] organization that coordinates Project 4… It's also important that consumers lead this campaign..' – Theme expressed by three individuals	Consumers will be highly involved in the implementation of Project 4. Specific leadership functions will be determined in the procurement process.

'We need to have integration among all programs and providers… be able to call each other and interact about our clients.' – Theme expressed by one individual	In the procurement process, organizations will be required to demonstrate their ability to collaborate with other providers across the County.
'We encourage the county to include community members in framing the RFP process.' – Theme expressed by one individual	The procurement process will be guided by County General Services Agency (GSA) requirements and the community input from the PEI Planning Process.
'How and where outreach occurs should be an important part of the RFP and scoring process… I hope that [trauma and violence] can be priority areas in the RFP write-up and scoring.' – Theme expressed by one individual	ACBHCS recognizes trauma, violence and effective outreach as important issues to address.
'There are existing evidence-based international tools and resources that can be used and adapted by some of the proposed programs.' – Theme expressed by one individual	It is the intention of ACBHCS to ensure that providers implement programs in accordance with best practices wherever possible.
'I urge the consideration of funding for increasing recruitment of service providers with a diversity of cultural/language backgrounds.' – Theme expressed by one individual	Projects 5-8 will increase ACBHCS's contracts with diverse providers. In addition, this is a focus of the MHSA Workforce, Education & Training Plan which will be released for public comment in fall 2008.

d. The estimated number of participants:

A total of 151 individuals were active during Phase IV. Individuals engaged by attending the meetings, providing written and spoken comment or both. 106 individuals attended the public comment meetings; eight individuals emailed feedback; and 37 attended the final Mental Health Board meeting.

Note: County mental health programs will report actual PEI Community Program Planning expenditures separately on the annual MHSA Revenue and Expenditure Report.

County: Alameda **PEI Project Name:** 1. Mental Health Consultation in Schools/Preschools **Date:** Draft 08/18/08

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☐	☐	☐
2. Psycho-Social Impact of Trauma	☒	☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☒	☐		
4. Stigma and Discrimination	☒	☐	☐	☐
5. Suicide Risk	☒	☐	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☐	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☐	☐	☐
3. Children and Youth in Stressed Families	☒	☐		
4. Children and Youth at Risk for School Failure	☒	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☐		

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

The PEI Community Planning Process found that many Alameda County children and youth live in stressed families and are exposed to various forms of trauma such as community and family violence. For example, 2004-2006 California Healthy Kids Survey data showed that about 10% of Alameda County 5th graders were home without adult supervision all or most of the time and that 35% never or only sometimes felt safe outside of school. The process also found that existing mental health services for children and youth are inadequate; that disparities exist in quality of care and that preK-12 schools are not effectively utilized as a mental health services resource for children and youth. According to national research, only 16% of American children receive any mental health services. Of those receiving care, 70-80% receive that care in a school setting.[1,2]

The PEI Community Needs and Priorities Survey identified the impact of trauma, the risk for onset of serious psychiatric illness and suicide as key needs. Additionally, children and youth at risk for school failure, at risk for suicide and for juvenile justice involvement, emerged as priority populations in Alameda County.

Distressed children and adolescents place high demands on caregivers and institutions, straining economic, social and emotional resources. Bay Area youth researchers, in partnership with the University of California, San Francisco found that 20-25% of their peers reported that they had considered suicide in recent months. National data indicates that 15% of high school students have seriously considered suicide and 7% have attempted suicide in the past year.[3]

The Ongoing Planning Council (OPC), in its deliberations as the primary stakeholder group for MHSA planning, has identified mental health programs in schools, preschools and childcare sites as a key strategy for local PEI funding.

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI Intervention.

This project provides an on-site Mental Health Consultant (MHC) to schools/preschools. A school may have a limited degree of mental health services, such as academic counselors, school nurses or special education psychologists, but not have adequate psychological counseling services to address the mental health needs of students outside of the special education program. Training and consultation to teachers and other school staff on recognition and effective response to early indicators of mental illness and the onset of psychosis will result in

[1] Rones M & Hoagwood K. School-Based Mental Health Services: A Research Review. Clinical Child & Family Psychology Review, Vol. 3, No. 4, 2000: 223-241.
[2] Burns BJ, Costello EJ, Angold A, Tweed D et al. Children's Mental Health Service Use Across Service Sectors, Health Affairs, Vol. 14, No. 3, 1995: 149-159.
[3] Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance (YRBS) – United States, 2007

opportunities for early intervention to reduce negative outcomes such as trauma, school failure, involvement in the juvenile justice system, hospitalization and suicide, which may be associated with untreated mental illness.

Students exhibiting emotional or behavioral distress will receive timely screening/evaluation by the MHC, who will also provide outreach to the family. Service provision will "meet the family where they are at" and focus on their goals through the development of a consumer-driven treatment plan. The student and his/her family will have the support of the MHC as a counselor and family advocate.

Underserved students and families lacking mental health support will receive a culturally responsive assessment, counseling and referral services to ameliorate emotional and behavioral barriers to learning. Through a multi-disciplinary team approach, the MHC will coordinate teachers, academic counselors, school nurses and other caring adults to broaden a youth's support network, including an array of individuals who share a similar racial/ethnic, cultural and linguistic heritage.

This project has been split into three components in order to address the needs of children and youth during different developmental stages through the project's expansion on the success of three distinct local program models. Each of the components is described in greater detail below:

- Component A targets the needs of children in preschool and childcare settings,
- Component B addresses the needs of children and youth in elementary and middle schools, and
- Component C targets the needs of youth in high schools.

Component A: Preschool and Childcare Settings

This component will include mental health consultation at a maximum of 12 preschool and childcare classrooms (depending on the size of the individual classrooms). About 250 children per year will benefit from the mental health consultation at these sites. Between 30-40 children at these sites will benefit from more intensive consultation with their teachers and families (also called "collateral" therapy) each year. This component builds upon the success of a number of existing local early childhood mental health consultation in preschool and childcare programs. Alameda County First Five coordinates a number of local early childhood mental health consultation programs that are provided through local community-based organizations (CBOs). ACBHCS also directly provides an early childhood mental health consultation program.

Component B: Elementary and Middle Schools

The Elementary and Middle School component will include clinical case management and consultation in 3-6 new elementary/middle school sites (depending on the size of the individual schools). About 1,500 children and youth per year will benefit from having these services at their schools. Between 75-135 students will benefit from brief therapy/case management or more intensive consultation/"collateral" therapy with their teachers and families each year. This component builds upon the Our Kids Program, which is currently run through the Alameda County Health

Care Services Agency (ACHCSA) School Health Services Coalition and now serves 28 local elementary and middle schools through this model.

Component C: High Schools

This component will include mental health consultation and coordination at two new place-based health and wellness centers that serve high school students. About 3,500 youth per year will benefit from having these services at their schools; between 200-400 key stakeholders including school staff, families and students will receive training on mental health issues each year; between 35-40 students will benefit from more intensive case management or consultation with their teachers and families each year. In addition, the Mental Health Consultant/Coordinator will provide the foundation for starting-up and coordinating a greater array of mental health counseling/therapy services at these sites. This component builds upon the School-Based Health Center model. School-Based Health Centers now sit in 10 high school sites in Alameda County. A number of additional high schools are planning new School-Based Health Centers, School-Linked Health Centers and School Wellness Centers. Mental health services at local School-Based Health Centers are now being provided by a number of different agencies including CBOs, school districts and city agencies. These services are currently coordinated through the ACHCSA School Health Services Coalition, which provides technical assistance (TA) to both existing and emerging program sites.

b. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

Easily accessible, on-site mental health consultation, which promotes early identification and referral, has been shown to effectively interrupt the progression to more serious issues such as school failure, involvement with the juvenile justice system and suicide.

School/preschool-based mental health services improve educational outcomes by decreasing absences and discipline referrals and improving test scores. There is growing evidence that school/preschool participation, success and academic achievement are negatively impacted by trauma and other unrecognized or untreated mental health conditions. One key to academic achievement and reduction of potential school failure is early identification of mental health issues and, when needed, provision of appropriate counseling and referrals. The General PEI Planning Panel selected this intervention as the most effective strategy to address the community needs relevant to children and youth and impact the desired outcomes described above.

This project creates an infrastructure of complementary interventions to provide solutions for underserved children and youth including:

- Providing in-class support for teachers to decrease stigma and assist with mental and behavioral health issues
- Making mental health services available at schools as a support for learning and parent engagement
- Increasing coordination of services to better leverage community mental health resources for schools.

Consumers report that schools are the most accessible place for delivery of mental health PEI for children. This PEI project enhances students' access to services by placing mental health services in schools. Schools are a primary setting for the potential recognition of mental health disorders in children and adolescents with half of all lifetime cases of mental illness beginning on or before age fourteen[4]. When unrecognized and untreated, mental disorders in childhood can lead to more severe, more difficult to treat illness as well as the development of co-occurring disorders in adulthood.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

This project will occur in a school setting and will be provided by a qualified local education agency or community mental health provider. District, school or classroom staff will work in collaboration with community based organizations to create a continuum of both school-based and school-linked services. This organization/setting has been chosen because schools are both easily accessible and culturally appropriate for youth. The most common denominator for Alameda County children and youth is school enrollment. A continuum of care will be created to decrease risk and foster resiliency through collaborative partnerships.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

This project targets preK-12th grade students and their families who are at risk for school failure, suspension/expulsion, suicide and involvement in the juvenile justice system due to conditions of poverty and exposure to trauma. Families are self-defined in this project and shall include non-custodial parents and guardians. The exact ethnic populations to be served will be determined by the location of these services within Alameda County. Current population data project the local school-aged population to be 32% Latino, 25% Asian/Pacific Islander (API), 25% White, 12% African American, 5% Multiracial and less than 1% American Indian.[5]

A number of high need communities exist throughout Alameda County. For example, 69% of the students that attend Oakland public schools are enrolled in the program for free and reduced price lunches, an indicator of economic need.[6] Many families living in conditions of poverty lack basic health insurance and mental health coverage. Research

[4] Surgeon's General Report on Mental Health, 1999.
[5] California Department of Finance Population Projection for 2010.
[6] California Office of Education, 2006-2007 data.

shows that the vast majority of youth in the juvenile justice system are economically disadvantaged, with African Americans representing a disproportionate 53% of the youth entering into juvenile hall.[7]

It is expected that the Preschool component will serve up to twelve preschool/childcare classrooms, with at least one classroom in each region of Alameda County. It is expected that the Elementary and Middle School component will serve three to six elementary/middle schools and the High School component will serve two new place-based health/wellness centers. Schools served by the Elementary and Middle School and High School components will likely be located in multiple regions of Alameda County.

e. Highlights of new or expanded programs.

This project serves to both initiate new services and expand existing services within Alameda County. As stated previously, there is an absence of adequate preventative mental health care for children and youth. There is however, a continuum of caring adults, family members, dedicated teachers and other school staff who want to be part of the solution.

The proposed interventions will link students and families with the available resources in the school and community including after-school enrichment, tutoring, mentoring, case management, assessment/evaluation, conflict mediation, family counseling, sports and recreation, community service and employment programs.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Program	*Frequency/Duration of Key Activities*
A: Preschool/ Childcare Settings	Ongoing consultation with 8-12 preschool/childcare classrooms/yr
	Collateral therapy (low-intensity, usually less than one year) to 30-40 families and children/yr
B: Elementary and Middle Schools	Ongoing consultation to 3-6 elementary/middle schools/yr
	Administration of at least one curriculum listed under 5b at each school/yr
	Brief therapy or collateral therapy (low intensity, usually less than one year) to 75-135 students/yr
C: High Schools	Ongoing training around mental health issues (length of between 45-120 min/training) to 200-400 key stakeholders connected to high schools that will be served by two planned place-based health/wellness centers/yr
	Administration of at least one curriculum listed under 5b at each school/yr
	More intensive case management or consultation (low intensity, usually less than one year) to between 35-45 families and students/yr

[7] Alameda County Probation Department June 2008 Monthly Statistical Report.

g. Key milestones and anticipated timeline for each milestone.

Aug. ’08 – Dec. ’08	Procurement process to solicit proposals for programs and identify the lead agencies and preK-12 educational sites where the services would be located for each of the components
Jan. ’09 – Mar. ’09	Program start-up, which would include recruitment, hiring and training of staff and program/infrastructure development
Apr. ’09	Program implementation by no later than April 2009

4. Programs

Program Title **Mental Health Consultation in Schools/Preschools**	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
A: Mental Health Consultation in Preschool/Childcare Settings (Annual target of individuals and families served: 250)	Individuals: 250 Families:*	Individuals: 15 Families:*	6 months
B: Mental Health Consultation in Elementary and Middle Schools (Annual target of individuals and families served: 1,500)	Individuals: 1,500 Families:*	Individuals: 38 Families:*	6 months
C: Mental Health Consultation/Coordination in High Schools (Annual target of individuals and families served: 3,500)	Individuals: 3,500 Families:*	Individuals: 18 Families:*	6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED (Annual target of individuals and families served: 5,250)	**Individuals: 5,250 Families:***	**Individuals: 71 Families:***	

* Please note that all interventions under this project will target the families and teachers of the students served.

5. Alternate Programs

☒ Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3).

a. The program has been selected based on a logic model (conduct an inclusive community planning process, identify desired PEI outcomes, match an appropriate program, evaluate results and improve programs).

This project has been selected based on the priorities identified through the local PEI Community Planning Process. The General PEI Planning Panel reviewed the priority needs of children and youth that were identified through the Community Input Process (i.e., focus groups, community input meetings, a community survey and community reports). The Panel then worked in collaboration to analyze the most essential individual and system level outcomes connected with each of the identified needs. Next, local intervention strategies with the greatest likelihood of high impact outcomes were developed. During the strategy identification and development stage, participants reviewed and discussed the sample programs listed in the PEI resource materials and other locally proven practices. The project's overall structure and sub-components are based on a logic model guided by input from local experts and based on research of local and out-of-county comparison programs that deliver services using a similar approach.

b. The program is likely to achieve the desired PEI outcomes (evidence-based practices, promising practices and/or locally proven practices), particularly among underserved populations to be served. The county will conduct an outcomes evaluation on the program (describe).

All three of the components under this project are based on existing local models (or locally proven practices) that are consistent with the PEI Community Needs, Priority Populations and principals.

The Preschool component, the local Early Childhood Mental Health Consultation Model, is based on the 'Early Childhood Mental Health Programs' from the PEI resource materials. As noted previously, this program is already being implemented with success in local preschool and childcare classrooms.

The Elementary and Middle School component, the local Our Kids Model, is currently used successfully in the Oakland and Hayward Unified School Districts to identify pupils with mental health needs and provide services through an organized cadre of mental health professionals working at those school sites. This is an umbrella project that will utilize many of the programs listed in the PEI Resource Materials as a part of their onsite mental health consultation. Through discussions with local school districts already implementing this model, it is likely that these curriculums could include the 'Red Flags Curriculum,' 'Strengthening Families Program (SFP),' 'Reconnecting Youth,' 'Trauma-Focused Cognitive Behavioral Therapy (TFCBT),' 'Parents and Teachers as Allies,' 'Signs of Suicide (SOS),' 'Coping and Support Training (CAST),' and 'Parent Project.'

The High School component, the School-Based Health Center Model, is another umbrella project that coordinates and delivers direct health care services in school settings. Through discussions with school districts that have existing School-Based Health Centers, it has been determined that this project will also utilize programs listed in the PEI Resource Materials which may include the 'Strengthening Families Program (SFP),' 'Reconnecting Youth,' 'Trauma-Focused Cognitive Behavioral Therapy (TFCBT),' 'Parents and Teachers as Allies,' 'Signs of Suicide (SOS),' 'Coping and Support Training (CAST),' and 'Parent Project.'

It is expected that each of the components listed above will utilize the evaluation methodologies and tools that have already been developed by local program models. In the procurement process, agencies will be asked to describe how they will evaluate the outcomes of these programs.

c. The program is sufficiently developed to carry out with fidelity.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the proposed project designs are sufficiently developed to meet fidelity standards. Programs chosen for review were selected for their histories of success in addressing the community needs and priority outcomes identified through our PEI Community Planning Process. Program budgets, resources, partnerships, goals, activities/services, and scale of operations were assessed and adapted to the development of a program design that could be implemented in Alameda County with the resources available. Program management and supervision needs were also assessed. The comparison programs researched for this project include:

- ACBHCS Early Childhood Consultation and Treatment Program
- ACHCSA Our Kids Program
- Alameda County School-Based Health Center Model
- West Contra Costa County Childcare Solutions Preschool Consultation Program
- Jewish Family and Children's Services of San Francisco, the Peninsula, Marin and Sonoma Counties Early Childhood Mental Health Consultation Program
- San Francisco Wellness Initiative at Newcomer High School

d. The program is consistent with the PEI Community Needs, Priority Populations and principles.

This program was designed in response to PEI Community Needs, Priority Populations and principals identified by the State and supported by Alameda County's Community Input Process, Planning Panels and Ongoing Planning Council.

6. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

Children and youth identified as displaying initial signs of mental distress will be screened by the on-site MHC and/or provider team. Children and youth whose symptoms warrant a more comprehensive evaluation will be referred to an appropriate provider of choice, including primary physician, local community mental health clinic, county mental health clinic and/or insurance provider. MHC's will maintain an updated list of local providers and develop relationships with those with whom they make referrals.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

Traditionally, schools have not been defined as mental health providers. However, individuals within schools, faith based organizations, recreation centers and after-school programs can and do make a significant positive impact on the mental health of children. While the primary responsibility of the MHC is to identify and reduce the impact of serious mental health issues, he/she will also work in collaboration with a variety of community supports to promote wellness and foster resiliency. These community supports will include Social Services, ACBHCS, alcohol and other drug prevention and treatment programs for youth (and families), violence prevention programs, mentoring programs, housing and employment programs and after-school recreation and enrichment. The MHC will also maximize educational resources by training teachers and administrators on mental health indicators and positive classroom management.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the budget and program design for this proposed project includes sufficient programs and activities to achieve desired PEI outcomes at the individual/ family, program/system and community levels. Through the procurement process, agencies will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes. Proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

7. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

In Alameda County, existing partnerships support the provision of school-based mental health and health care services through programs, such as Our Kids or School-Based Health Centers at a number of local school sites. A majority of schools and school districts have existing partnerships with community based service organizations developed through an extensive implementation of Early Periodic Screening, Diagnosis and Screening (EPSDT) funded school-based services.

The MHC will leverage and expand upon these partnerships in an effort to link more students and families with appropriate levels of care. The MHC will identify and facilitate student and family access to culturally appropriate mental health care services, substance abuse programs, and other county and school-sponsored resources. This will be a particular focus for children, youth and families who have been inappropriately served or underserved. An overall effort will be made to link families with a community networks reflective of their cultural background. To underscore and address concerns of stigma as a barrier to seeking assistance, this project will collaborate with the Stigma and Discrimination Reduction Campaign Project that is being funded through PEI. Similarly, linkages with programs in underserved ethnic and language communities will be enhanced by collaboration with the Latino, API, South Asian/Afghan, and Native American Projects also funded through PEI.

b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

Easily accessible, on-site mental health consultation, which promotes early identification and referral has been shown to effectively interrupt the progression to more serious issues. Early identification and referral to appropriate community resources will assure that the local community-based mental health and primary care systems will have an opportunity for earlier intervention, which will enhance the effectiveness of those other systems.

Training and consultation will engage families and other caregivers to better understand the relevance of concerns and risk factors of mental illness. Discussions and engagement of community-based services and the primary care system can also mitigate stigma commonly associated with seeking mental health services.

Distressed children and adolescents place high demands on caregivers and institutions, straining economic, social and emotional resources. By providing preventative screening, early intervention and follow-up treatment through linkages to primary care providers, health clinics and community mental health centers, a gap in services can be closed to prevent significant harm to children and the community at large.

c. Describe how resources will be leveraged.

Early intervention, in partnership with schools/preschools and community organizations, will leverage city, county, and state dollars to increase access and broaden the infrastructure of support for children, youth and families. In return, schools/preschools and community organizations will provide significant in-kind support including space, equipment, staff and volunteer time, referrals, cross-training, access to caseloads, tutoring, mentoring, after-school programming, general funding and opportunities for Medi-Cal reimbursement. In partnership with existing county, state and community organizations, Mental Health Consultation in schools/preschools will be sustained through leveraging existing resources, and/or ongoing fund development. In the procurement process, agencies will be asked to describe their plan for leveraging additional resources and/or funding.

d. Describe how the programs in this PEI project will be sustained.

The programs in this PEI project will be sustained through continued MHSA funding. As part of implementation, ACBHCS will assess potential providers' management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Quarterly progress reports and follow-up will be scheduled to address any emergent issues. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through ongoing MHSA funding.

8. Intended Outcomes

The General PEI Planning Panel reviewed the priority needs of children and youth that were identified through the Community Input Process. The Planning Panel worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to these desired outcomes.

Component	Individual Outcomes	System/ Program/ Community Outcomes	Proposed Methods/ Measures of Success
A. Preschool/ Childcare Settings B. Elementary and Middle Schools C. High Schools	• Increased number of school staff that are trained in recognition of early indicators of mental illness and how to refer students for screening and intervention • Increased knowledge of social, emotional and behavioral issues • Increased knowledge of risk and protective factors • Enhanced resilience and protective factors, mental health status, early-age attachment, social support, attendance, and academic achievement • Reduced suspensions/expulsions, drop-out rates, violence, social isolation, and involvement with law enforcement/courts	• Provision of MHCs to local schools • Enhance the capacity of schools/preschools to identify individuals and families with social, emotional and behavioral issues • Improve PEI supports for children, youth and families • Increased number of individuals and families that will receive and benefit from PEI services • Increase access to mental health services for under/ inappropriately served children and their families	• Tracking logs to measure numbers exposed to educational messages and number of referrals • Surveys or focus groups to measure change in knowledge/attitudes about mental illness and when/ how to refer • MHC records of student progress on individualized treatment goals • Consumer satisfaction surveys that assess client/family satisfaction and improvement in presenting problems • Quantitative analysis of identified referrals, frequency of contact, and associated reduction in suspension/expulsion

What will be different as a result of the PEI project and how will you know?

Consumers, family and the community will see a higher rate of engagement by school staff and families in the proactive resolution of behavioral health issues. School/preschool-based mental health services will improve

educational outcomes by decreasing absences and discipline referrals and improving test scores. The community will see an improvement in services as measured by satisfaction surveys due to increased collaboration among mental health services and education. School staff and teachers will show an increased knowledge of children and youth's social, emotional and behavioral issues. For example, a 2006 survey of teachers showed that 51% felt that mental health consultation changed the way they thought about children's emotional development and 72% reported it changed the way they thought of children's social development.

Research has shown that school-based mental health consultation is efficacious in increasing young people's access to and utilization of services, enhancing their protective factors and resilience, and decreasing over the long term negative outcomes that can be associated with untreated mental illness such as school failure, juvenile justice involvement, the onset of serious mental illness, and suicide. In addition, the integration of mental health services into schools has been shown to create a more seamless service delivery system for children, youth and their families.

Below is a brief narrative that describes what we expect to be different with respect to a typical situation addressable through this program:

"A child had repeated tantrums on the way to school and was labeled a 'problem' child by his teacher. He was threatened with expulsion if he didn't learn to behave. Although the child had difficulty regulating his emotions, our MHC determined that other factors were at work as well. The MHC first established a relationship with his teacher so she could request help with the child. Through a reflective process they explored how he was getting negative attention at school and [the teacher] began to give him some positive feedback after the consultant focused on his strengths. The family worked with the consultant on positive discipline strategies and how to become his advocate. The child is now transitioning more smoothly from home to school without tantrums."

9. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

The CSS Plan created the Alameda County Wellness, Recovery and Resilience Hub and the Alameda County Family Education and Resource Center (FERC). The Hub will consult with staff and managers of this PEI project to ensure that wellness and recovery practices are embedded in the project's main activities. Staff hired for this project will receive in-service training conducted by the Wellness, Recovery and Resilience Resource Trainers and ongoing support. The FERC will provide direct support, information, and assistance for family members who are engaged with ACBHCS through this and other projects. As a result of these supports, this project will develop its own capacity to orient, guide and support family members.

PEI projects will be oriented to all CSS activities, in addition to all of the ACBHCS non-MHSA programs, so they can develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

The ACBHCS's Workforce, Education and Training (WE&T) Planning Panel has developed a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community in which we serve. PEI and WE&T programs will partner in areas of staff recruitment and training.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

At this time, no Capital Facilities and Technology funds have been identified for this project.

10. Additional Comments (optional)

N/A.

County: Alameda **PEI Project Name:** 2. Early Intervention for the Onset of First Psychosis and Serious Mental Illness Among Transition-Age Youth **Date:** Draft 08/18/08

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☒	☐	☐
2. Psycho-Social Impact of Trauma	☐	☒	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☐	☒		
4. Stigma and Discrimination	☐	☒	☐	☐
5. Suicide Risk	☐	☒	☐	☐

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☐	☒	☐	☐
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☒	☐	☐
3. Children and Youth in Stressed Families	☐	☒		
4. Children and Youth at Risk for School Failure	☐	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☒		

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

The PEI Community Input Process found that transition age youth (TAY) and families are under-educated about mental health issues. For example, behaviors assumed to be associated with adolescent stress can, in fact, be signs of a first psychotic episode. There is little knowledge among TAY and families about the effects of trauma on mental health or the risk factors for serious mental illness (SMI) and suicide. The stigma and discrimination faced by individuals with mental illness were identified as critical barriers to seeking information and treatment.

TAY were designated as an underserved population by the MHSA planning data and the PEI Community Input Process noted that TAY have a unique set of cultural experiences and needs. There are currently no local specialized services for TAY experiencing symptoms of their first psychotic episode. Alameda County's adult crisis centers handle close to 40 TAY per year who present symptoms of early onset. Furthermore, there are up to 300 psychiatric hospitalizations for TAY each year; many more TAY enter the juvenile and criminal justice systems because of antisocial behavior that may be related to untreated mental illness, thus it is likely that these youth would benefit from early intervention.

Symptoms of early psychosis in TAY often go unrecognized and untreated until a psychotic break is experienced. Although the numbers of individuals experiencing psychosis in the general population is only 1-2%, many adults in the mental health system were initially diagnosed in adolescence or young adulthood. Early intervention and treatment may have prevented their mental illness from becoming chronic or disabling.

There is a general acknowledgement that the lack of community mental health services for TAY experiencing onset of SMI is a significant gap in the system. The Ongoing Planning Council (OPC), the primary stakeholder group for MHSA planning, has consistently identified programs for TAY experiencing onset of SMI as a priority for local PEI funding.

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI intervention

Component A: Outreach and Education

This component focuses on risk factors for SMI and psychosis by incorporating community collaboration for outreach, education, training, consultation and triage. Activities for this component include:

- Linkage with the anti-stigma campaign to deliver community education and local media via articles, interviews and presentations about mental health issues. Messages will include stigma reduction, effectiveness of early intervention, how to identify early symptoms and risk factors for serious mental health issues and where to get help.
- Targeted training and consultation to individuals and institutions likely to come into contact with young persons who may experience signs of SMI to reduce disparities within this age group.

- Strategies will be tailored to different groups including TAY, parents/families, foster families, child welfare workers, high schools/community colleges, vocational programs, police and probation, medical providers, etc.
- Youth involvement in all efforts is a key component of reaching TAY including youth-friendly language and youth designed websites that engage youth through emerging web-based communities.
- Use of technological advancements that are a central form of communication for TAY. For example, web-based communities, blogs, websites and cell-phone text messaging are possible methods for conducting outreach and education for this population.

o Linking families to existing resources by creating an accessible resource and referral guide. Youth identified as being at risk for SMI would be referred to community resources, such as those listed under Component B (below).

Component B: Community-Based Treatment

Community-Based Treatment will provide assessment and community-based treatment with clinical and support services to young people demonstrating early signs of psychotic episodes and auxiliary services for their caregivers. Family psycho-educational services will be provided for TAY displaying early signs of psychosis and comprehensive services will be provided to TAY who have experienced an episode of untreated psychosis within the prior two years. This component is based on wellness, recovery and resiliency principles to restore youth to health. It creates partnerships with families to build comprehensive services for the youth to prevent hospitalization. A culturally diverse parent-youth advisory board will help to create policies and procedures that are relevant and culturally appropriate for TAY. This component will serve about 60 new clients per year and the average duration of services will be two years. Services will include:

- Training providers on identification and treatment of early psychosis
- Assessment of TAY interested in program and development of treatment plans
- Individualized case management to young people enrolled in the program
- Crisis intervention and stabilization
- Ongoing counseling to support individual and family coping and recovery
- Clinical services supporting low or no dose medication
- Supported education/employment services to allow youth to more quickly return to work or school
- Training family members to partner with youth using psycho-education, group and individual family support
- Cognitive interventions, creative therapies, stress reduction and complementary healing
- Peer support and mentoring
- Substance abuse services
- Linkage to medical services.

b. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

TAY with unrecognized, untreated symptoms of mental illness often experience a "first break" before receiving any mental health treatment; this often results in school failure, incarceration, homelessness, hospitalization in psychiatric institutions and even suicide. Research shows that early intervention can reduce the negative outcomes associated with untreated mental illness. The goal of this project is to build awareness in the community about the onset of SMI among TAY, educate the community on the effectiveness of early intervention and provide culturally appropriate treatment.

The General PEI Planning Panel selected this two-pronged intervention as the most effective strategy for addressing TAY community needs and impacting the outcomes described above. Psychotic symptoms associated with onset of serious and persistent mental health disorders most commonly emerge during adolescence or young adulthood. Services for this population are needed to bridge the transition between the children and adult systems of care.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

Services will most likely be coordinated by a community-based provider with experience serving the TAY population. Implementation partners will be diverse and include schools and colleges, child welfare, police and probation, primary and behavioral health care, and other organizations/agencies in frequent contact with TAY.

Outreach and Education will take place wherever young people congregate:

- Schools, including high schools, continuation schools, community colleges and vocational schools
- Social settings, including libraries, internet cafes, community centers, faith-based organizations, sports clubs, and youth centers
- Independent living skills programs, for former foster youth
- Correctional settings, including police and probation departments
- Treatment settings, including those for drug treatment
- Primary care settings, including pediatricians, school-based health centers, community health centers.

The Community-Based Treatment component will be delivered in a community-based out-patient treatment setting with staff trained in delivering services to youth at high risk for a first psychotic episode. As a youth is able to return to his/her usual activities, services would follow him/her into:

- Schools, including high schools, continuation schools, community colleges and vocational schools
- Social settings like the "Club-house" model, including libraries, internet cafes and community centers
- Correctional settings, including police and probation departments
- Employment settings.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

This project targets TAY aged 16-24 years at a high risk for onset of SMI, particularly psychosis. This includes youth who may experience co-occurring drug related issues. TAY make-up one-tenth of all Alameda County residents and they, as a cohort, have a unique set of cultural experiences and needs. Current population data project the 16-24 TAY population in Alameda County to be 29% Latino, 28% White, 23% Asian/Pacific Islander (API), 14% African American, 4% Multiracial and 1% American Indian.[8] TAY are often inadequately served by the children's and the adult system. TAY were designated as an under-served population by MHSA planning data.

It is expected that this project will be physically located in a North or Central location in Alameda County due to the high concentration of TAY living in poverty. Outreach and education services will be provided throughout Alameda County. Ultimately, treatment services will be available to youth from all regions. All activities will be inclusive of and address cultural diversity during development, implementation and evaluation. This project will link with existing community organizations to provide culturally and linguistically appropriate education and outreach to TAY. Many community organizations have developed culturally appropriate ways to reach their youth and collaborations with these organizations will build on those customs. For example, the Native American community uses culturally-based rituals and custom to promote healing and a sense of community for youth.

e. Highlights of new or expanded programs.

The Outreach and Education component will strengthen the capacity of existing community programs and services to identify youth with mental health issues. It will create awareness in the community and reduce stigma to identify young people at risk for SMI before symptoms become debilitating. This component will link families to existing resources by creating an easily accessible resource and referral guide. The Community-Based Treatment component will train providers in an evidence-based practice model to help young people experiencing early signs of psychosis return to school or employment. Through psycho-education, families will learn how to support youth and each other to

[8] California Department of Finance Population Projection for 2010.

prevent subsequent breaks. Substance abuse services, peer mentoring and other support services will promote recovery and resiliency of young people.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Program	*Frequency/Duration of Key Activities*
A: Outreach and Education	Train about 600 individuals, including professionals, families and TAY (about 45-120 min/trainings) and respond to about 200 inquiries/yr.
B: Community-Based Treatment	Serve about 60 new clients/year through community treatment. Average length of services would be approximately two years.

g. Key milestones and anticipated timeline for each milestone.

Aug. '08 – Dec. '08	Procurement process
Jan. '09 – Mar. '09	Program start-up, which would include recruitment, hiring and training of staff and program/infrastructure development
Apr. '09	Program implementation by no later than April 2009

4. Programs

Program Title **Early Intervention for the Onset of First Psychosis & Serious Mental Illness Among Transition Age Youth**	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
A: Outreach and Education (Annual target of individuals and families served: 700)	Individuals: 147 Families: 153	Individuals: 49 Families: 51	6 months
B: Community-Based Treatment (Annual target of individuals and families served: 60)	Individuals: Families:	Individuals: 10 Families:*	2 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED (Annual target of individuals and families served: 700)	**Individuals: 147** **Families: 153**	**Individuals: 49** **Families: 51**	

* Please note that the Community-Based Treatment component will also target the families of the TAY served.

5. Alternate Programs

☐ Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3).

a. The program has been selected based on a logic model (conduct an inclusive community planning process, identify desired PEI outcomes, match an appropriate program, evaluate results and improve programs).

This project is based on a *Study Group Proposal on Early Intervention at the Onset of Psychosis* that was highlighted as a best practice in the Community Input Process. The General PEI Planning Panel reviewed the priority needs of TAY that were identified through the Community Input Process (i.e., focus groups, community input meetings, a community survey and community reports). The Panel then worked in collaboration to analyze the most essential individual and system level outcomes connected with each of the identified needs. Next, local intervention strategies with the greatest likelihood of high impact outcomes were developed. During the strategy identification and development stage, participants reviewed and discussed the sample programs listed in the PEI resource materials and other locally proven practices. The project's overall structure and subcomponents are based on a logic model guided by input from local experts and based on research of local and out-of-county comparison programs that deliver services using a similar approach.

b. The program is likely to achieve the desired PEI outcomes (evidence-based practices, promising practices and/or locally proven practices), particularly among underserved populations to be served. The county will conduct an outcomes evaluation on the program (describe).

This project is based on the Portland Identification and Early Referral Program (PIER), which is an evidence-based practice listed in the PEI Resource Materials. This project has been selected as the PEI project that Alameda County will evaluate and report to the state. In the procurement process, agencies will be asked to provide more detail about how they will evaluate the outcomes of these programs.

c. The program is sufficiently developed to carry out with fidelity.

ACBHCS Administration conducted research on out-of-county comparison programs to ensure that the program design for the proposed project is sufficiently developed to meet fidelity standards. Programs chosen for review were selected for their histories of success in addressing the community needs and priority outcomes identified through our PEI Community Planning Process. Program budgets, resources, partnerships, goals, activities/services, and scale of operations were assessed and adapted to the development of a program design that could be implemented in Alameda County with the resources available. Program management and supervision needs were also assessed. The

comparison programs researched for this project include the PIER program in Maine and the Early Assessment and Support Team (EAST) program in Oregon.

d. The program is consistent with the PEI Community Needs, Priority Populations and principles.

This program was designed in response to PEI Community Needs, Priority Populations and principals identified by the State and supported by Alameda County's Community Input Process, Planning Panels and Ongoing Planning Council.

6. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

The served population will be linked to existing services through outreach and education efforts geared at TAY as well as their key contacts, such as schools, pediatricians, coaches, child welfare workers, police and other first responders, personnel at existing 51/50 sites, drug/alcohol specialists, personnel from churches and other community programs, families and the youth themselves by offering training and outreach education. This project will link community and families to resources by creating a resource guide and a referral mechanism to mental health or primary care services when needed. High risk youth will be referred to a program which utilizes evidence–based models to mobilize them to return quickly to a healthy life.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

This project will link community and families to resources through a resource guide and referral mechanism to other types of services including substance abuse treatment, violence and basic needs services. Currently, most families and community members do not know where or how to access TAY resources.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

ACBHCS Administration conducted research on out-of-county comparison programs to ensure that the budget and program design for this proposed project includes sufficient programs and activities to achieve desired PEI outcomes

at the individual/ family, program/system and community levels. Through the procurement process, agencies will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes. Proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

7. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

Collaboration with communities and building on their demonstrated practices for reaching youth will make the Community Education and Treatment component effective. Partnerships will be built with families, youth and other key individuals who come into contact with TAY. One partner will be the Family Resource Center funded under the MHSA CSS Planning Process. Other key partners include youth centers, faith based institutions, schools, foster care families, police and coaches. This project will collaborate with the Stigma and Discrimination Reduction Project that is being funded through PEI in order to address concerns around stigma as a barrier to seeking assistance. Similarly, linkages with programs in underserved ethnic and language communities will be enhanced by collaboration with the Latino, API, South Asian/Afghan and Native American Projects also funded through PEI.

b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

Outreach and Education will strengthen the capacity of existing community programs and services to address mental health issues. It will create awareness in the community and reduce stigma to identify young people at risk for psychosis before symptoms become debilitating. Training and consultation will engage families and other caregivers through a greater understanding of risk factors for mental illness. It will increase family and provider awareness of the early symptoms of SMI and where to find treatment. The Outreach and Education component will also collaborate with consumer-run and family member-run organizations such as Peers Envisioning and Engaging in Recovery Services (PEERS), the Pool of Consumer Champions (POCC) and the National Alliance on Mental Illness (NAMI). The Outreach and Education component will link with the existing local network of school-based health centers and other community-based mental health and primary care providers. Early identification and referral to appropriate community resources will assure that these local mental health and primary care systems will have an opportunity for earlier intervention, which will enhance the effectiveness of those systems. This component will also link families to other existing resources by creating an easily accessible resource and referral guide.

The Community-Based Treatment component will train providers in an evidence-based model to help young people experiencing early signs of psychosis, which will enable youth to return to school or employment. Family services, substance abuse services and peer mentoring will support youth in their recovery. Currently, there is no specific program to treat youth experiencing the first signs of SMI in Alameda County. With the proposed project, primary care and other local providers will have a resource to which they can refer young people about whom they are concerned. TAY will be referred back to programs in their community as quickly as possible for supportive services.

c. Describe how resources will be leveraged.

Outreach and Education will leverage the efforts of the Stigma and Discrimination Reduction Campaign, including activities of PEERS, POCC and the Wellness and Recovery Resource Center. Health education classes at schools and websites that offer public service announcement spots can also be utilized. Community organizations can offer in-kind funding for public education and training. Community-Based Treatment will leverage Medi-Cal reimbursement for many of its services provided to eligible participants. In the procurement process, agencies will be asked to describe their plan for leveraging additional resources and/or funding.

d. Describe how the programs in this PEI project will be sustained.

The programs in this project will be sustained through continued MHSA funding. As part of implementation, ACBHCS will assess potential providers' management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through ongoing MHSA funding.

8. Intended Outcomes

The General PEI Planning Panel reviewed the priority needs of TAY that were identified through the Community Input Process. The Panel worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to these desired outcomes.

Component	Individual Outcomes	System/ Program/ Community Outcomes	Proposed Methods/ Measures of Success
A. Outreach and Education B. Community-Based Treatment	• Earlier identification of SMI among TAY, reduced stigma and quicker access to resources • Reduction in length of untreated psychosis for TAY referred to community-based treatment • Improved level of functioning measured by Global Assessment of Functioning (GAF) and Structured Interview for Prodomal Syndromes (SIPS) • Enhanced resilience and protective factors, social support, recovery, and academic achievement • Decreased number of TAY with repeated episodes of untreated psychosis and decreased rates of hospitalization, suspension/ expulsion, drop-out, social isolation, and involvement with law enforcement/courts	• Increased number trained in early identification of SMI and how to refer TAY to early treatment services • Development of a resource guide and a referral mechanism that is accessible on the web or by phone • Early, more timely and more comprehensive response to referrals of TAY who may be at-risk for psychosis • Clinicians in the program will be trained on the GAF and SIPS tools • Increased number of TAY served through the new early intervention services	• Training Log • Training Evaluation • Intake Assessment • Change in GAF and SIPS Scores over time • Monthly monitoring of height, weight, blood pressure and side effects for TAY on medications • Follow-up interview or survey with those seen for clinical services • Interviews or surveys with diverse key informants working with TAY

What will be different as a result of the PEI project and how will you know?

The goal of this project is to change a fail first system to one of early awareness, hope and access. Consumers, family members and the community will see a more seamless system of support for TAY through increased trainings, linkages and collaborations. This project will reduce the negative outcomes associated with untreated mental illness by

increasing early identification and treatment through an increased number of providers that will be trained on recognition and treatment of early onset of SMI among TAY. The outcomes of this project have shown that youth receiving the described community-based treatment services are more likely to return to their prior lives and less likely to experience subsequent psychotic episodes.

9. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

The CSS Plan created the Alameda County Wellness, Recovery and Resilience Hub and the Alameda County Family Education and Resource Center (FERC). The Hub will consult with staff and managers of this PEI project to ensure that wellness and recovery practices are embedded in the project's main activities. Staff hired for this project will receive in-service training conducted by the Wellness, Recovery and Resilience Resource Trainers and ongoing support. The FERC will provide direct support, information, and assistance for family members who are engaged with ACBHCS through this and other projects. As a result of these supports, this project will develop its own capacity to orient, guide and support family members.

PEI projects will be oriented to all CSS activities, in addition to all of the ACBHCS non-MHSA programs, so they can develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

The ACBHCS's Workforce, Education and Training (WE&T) Planning Panel is in the process of developing a Training Institute, which would offer training for staff throughout our internal and community-based organization (CBO) system further training in how to recognize signs of onsets of first psychoses and SMI among TAY. As participants in the program progress in learning to manage themselves and their illness, work options will offer TAY a chance to contribute back to society. They may be drawn to the field of mental health through their own experience, and be at an impressive stage in life to battle stigma and discrimination in regards to the mental health field. PEI and WE&T programs will partner in areas of staff recruitment and training.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

At this time, no Capital Facilities and Technology funds have been identified for this project.

10. Additional Comments (optional)

N/A.

County: Alameda **PEI Project Name:** 3. Mental Health-Primary Care Integration for Older Adults **Date:** Draft 08/18/08

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☐	☐	☒
2. Psycho-Social Impact of Trauma	☐	☐	☐	☒
3. At-Risk Children, Youth and Young Adult Populations	☐	☐		
4. Stigma and Discrimination	☐	☐	☐	☒
5. Suicide Risk	☐	☐	☐	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☐	☐	☐	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☐	☒
3. Children and Youth in Stressed Families	☐	☐		
4. Children and Youth at Risk for School Failure	☐	☐		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Alameda County's 2005-2006 Community Services and Supports (CSS) Planning Process identified older adults, particularly Latino and Asian/Pacific Islander (API) older adults, as a highly underserved population. This project was originally developed during Alameda County's CSS Planning Process and included in the CSS implementation plan as the primary strategy to serve older adults residing in Central Alameda County. However, the local Stakeholder Group deemed the project to be more appropriate to the parameters, goals and outcomes of the PEI funds.

The CSS Planning Process found that older adults with untreated mental health issues are likely to have experienced trauma from loss of social support and inability to care for themselves. They are also at high risk for homelessness, medical and psychiatric hospitalization, frequent emergency room (ER) visits and premature death from causes such as suicide. Stigma and discrimination have been identified as common barriers to the receipt of needed mental health services in the older adult population. Based on estimates of prevalence of persons with serious mental illness (SMI), older adults with incomes less than 200% of the poverty level are significantly underserved. It is estimated that only 19% of low-income seniors with SMI receive mental health services.[9]

Frequent visits to a community clinic or ER may indicate that an older adult has mental health issues with which he/she is unable to independently cope. Many of these older adults have undiagnosed mental illness, yet continue to use ERs to receive treatment for presenting medical problems. These mental health issues, while chronic, may not be acute enough to consider the individual to be a danger to self, or others, nor require involuntary hospitalization for mental health treatment under conservatorship laws. However, the underlying mental health concerns, when inadequately addressed, often lead to multiple return visits to the ER.

There is evidence that API and Latino older adults are being underserved in the realm of mental health. Emotional issues like depression and anxiety impair the daily activities of 12% of California's older adults. One-quarter of California's elder population reports that they do not feel calm and peaceful most of the time. Those most likely to report mental health issues include elders of color, those who speak limited English and Medi-Cal recipients.[10] Delivering linguistically, culturally and geographically accessible mental health services are crucial to reducing the suffering of the SMI API and Latino older adults and their families. In addition to the needs listed above, older API and Latino populations experience additional disparities in access to mental health services.

[9] Based on 2005-2006 ACBHCS service data and Census 2000 population data.
[10] California Mexican Health Initiative Mental Health Fact Sheet, 2005.

Older Latinos and APIs may be less adaptable to the new American culture and adhere more strongly to traditional values. As a group, Latinos and APIs rarely seek traditional mental health services and terminate treatment earlier due to a variety of reasons such as:

- Varying levels of enculturation and acculturation
- Lack of knowledge or understanding about available mental health services
- Non-availability of culturally sensitive forms of treatment
- Linguistic barriers
- Previous negative experience with inappropriate Western mental health services.

In Alameda County, approximately 31% of households speaking API languages, and 23% of Spanish-speaking households are linguistically isolated, meaning that there are no members over 14 years of age speak English "very well."[11] The tendency to manage and maintain mental illness with the exception of severely disruptive family dynamics also leads to decreased rates of service utilization. A client's degree of assimilation is a significant factor in the counseling process and greatly affects outcomes. Clients who strongly adhere to traditional values may hesitate to seek mental health services due to stigma and be less forthcoming about their personal problems than a client with lesser adherence to traditional values.

The Latino Population

According to the California Mexican Health Initiative Mental Health Fact Sheet 2005:

- Among Latino Americans with a mental disorder, fewer than one in eleven contact Mental Health Specialists and less than one in five contact general health care providers. The utilization rates are even lower among Latino immigrants.
- While the percentage of mental health professionals who speak Spanish is not known, only about 1% of licensed psychologists, who are members of the American Psychological Association, identify themselves as Latino. Moreover, there are only 29 Latino Mental Health professionals for every 100,000 Latinos in the United States, compared to 173 non-Latino White providers per 100, 000 non-Latino Whites.

[11] Census 2000.

The Asian/Pacific-Islander (API) Population.

According to the Surgeon General's 2001 Report:

- Nearly half of APIs have problems with availability of mental health services due to limited English proficiency and lack of providers who have appropriate language skills.
- It has been estimated that about 21% of APIs lack health insurance. The rate of public health insurance for API's with low income, which are likely to qualify for Medicaid, is well below that of Whites from the same income bracket.
- API's have lower rates of utilization when compared to Whites. This under-representation in care is characteristic of most API groups, regardless of gender, age and geographic location. Among those who use services, the severity of their condition is high, suggesting that they delay using services until issues become very serious. Stigma and shame are major deterrents to their utilization of services.

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI intervention

Due to the stigma associated with mental health treatment, many older adults present their mental health issues as physical health concerns. In many instances, community clinics and ERs are the only way for older adults to receive treatment for what they perceive to be physical problems. Therefore, the availability of mental health screenings and services in community clinics and ERs would address the disparities in access to mental health services and the stigma associated with mental health treatment.

It is important to note that the recommended model is not a co-location of a traditional mental health service in a primary care setting, but rather a "nesting" of a Mental Health Specialist in the exam area. Furthermore, a Geriatric Assessment Response Team (GART) consisting of Primary Care and Mental Health Specialists will be a resource to ERs for assessment and short-term mental health treatment or linkage to an appropriate level of care.

This project will create a real-time collaborative relationship between community clinic, ER staff and Mental Health Specialists. This strategy includes, mental health outreach and education for older adults in ethnic Community Clinics and ERs in Central Alameda County.

Component A: Mental Health-Primary Care Integration for Older Adults in a Latino-Serving Community Clinic

Primary care staff in a Latino-serving community clinic will be educated on how to effectively identify, screen and refer older adults who are presenting medical issues to a non-stigmatizing mental health treatment setting. A review of service records will determine the initial target group: low-income older adults who visit the clinic five or more times over a six-month period. An analysis of the data by mental health outreach staff, in collaboration with clinic staff, will identify patients who are most likely to have mental health issues. These individuals will receive priority screening

during clinic visits and possible outreach when necessary. This component will help to address mental health disparities, stigma and discrimination experienced by individuals in this population. Additionally, the funneling of clients to mental health services will help to reduce the negative effects of trauma, mental illness and risk of suicide.

A Mental Health Specialist will be imbedded in the primary care exam area. If an individual's screening shows any warning signs, the Primary Care Specialist, will provide the client with a warm hand-off to the Mental Health Specialist for a consultation.

Component B: Mental Health-Primary Care Integration for Older Adults in an API-Serving Community Clinic

This component includes the same intervention that is described above, but located in an API-serving community clinic.

Component C: Mental Health-Primary Care Integration for Older Adults in Emergency Rooms (ERs)

A GART will be available to ERs in Central Alameda County for assessment, short-term case management, brief treatment, linkage and referral to necessary services including a higher level of mental health support, if needed. Onsite brief therapy will be provided by mental health staff and referrals will be made to more intensive services as needed in the case of severe trauma, for example. Primary care and mental health staff will collaborate to review and revise intake and triage procedures that identify mental health issues amongst any older adults visiting the ER. In the case of a mental health diagnosis, the older adult will be referred to the Mental Health Specialist to develop a brief treatment, recovery plan and referrals as needed, in consultation with the patient, the patient's physician and family members as appropriate. Short term treatment and referrals will be provided on an as-needed basis.

b. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The CSS Planning Process identified this project as an effective method to address the specific needs of older adults. Accessible and voluntary mental health services that are nested in a primary care setting to promote early identification of mental health issues and appropriate referral have been shown to effectively interrupt the progression to more serious issues.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

This project will establish routine screenings at community clinics that serve Latino and API older adults. The organizational partners will be two community clinics in Central Alameda County that already serve Latino and API

older adult populations. These organization partners will provide mental health screenings and referrals to older adults who may be experiencing mental health issues.

A GART from a community mental health agency located in Central Alameda County will be deployed when ERs identify older adults who need mental health screenings and referrals. The organizational partners for this component will be the community mental health agency providing the GART and ERs in Central Alameda County.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

This project targets older adults, particularly Latino and API older adults, aged 60 years and over with mental health issues. There are an estimated 3,000 older adults in Alameda County who are living in poverty and likely to have SMI. One-third of this total is Latino or API. This project will be located in and serve older adults of Central Alameda County.

e. Highlights of new or expanded programs.

This is a new program.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Program	*Frequency/Duration of Key Activities*
A: Latino-Serving Community Clinic	Orientation and ongoing training of pertinent primary care staff at one Latino-serving community clinic per year. Brief non-stigmatizing screening provided to between 85-100 Latino older adults per year. Brief therapy (low intensity, usually less than one year) provided to between 25-50 Latino older adults per year.
B: API-Serving Community Clinic	Orientation and ongoing training of pertinent primary care staff at one API-serving community clinic per year. Brief non-stigmatizing screening provided to between 85-100 API older adults per year. Brief therapy (low intensity, usually less than one year) provided to between 25-50 API older adults per year.
C: Emergency Rooms	• Brief orientation and ongoing training of pertinent staff at a minimum of one ER per year. • Referral to a Geriatric Assessment Response Team (GART) for assessment and short-term counseling, linkage and referral to necessary services including a higher level of mental health support, if needed.

g. Key milestones and anticipated timeline for each milestone.

Aug. '08 – Dec. '08	Procurement process
Jan. '09 – Mar. '09	Program start-up which would include recruitment, hiring and training of staff and program/infrastructure development
Apr. '09	Program implementation by no later than April 2009

4. Programs

Program Title **Mental Health-Primary Care Integration for Older Adults**	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
A: Mental Health-Primary Care Integration for Older Adults in an API-Serving Community Clinic (Annual target of individuals and families served: 85)	Individuals: Families:	Individuals: 43 Families:*	6 months
B: Mental Health-Primary Care Integration for Older Adults in an API-Serving Community Clinic (Annual target of individuals and families served: 85)	Individuals: Families:	Individuals: 43 Families:*	6 months
C: Mental Health- Primary Care Specialists Team for Older Adults serving Emergency Rooms (ERs) in Central Alameda County. (Annual target of individuals and families served: 45)	Individuals: Families:	Individuals: 23 Families:*	6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED (Annual target of individuals and families served: 215)	**Individuals:** **Families:**	**Individuals: 109** **Families:***	

* Please note that the interventions under this project may also address some families of the older adults served.

5. Alternate Programs

☒ Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3).

a. The program has been selected based on a logic model (conduct an inclusive community planning process, identify desired PEI outcomes, match an appropriate program, evaluate results and improve programs).

This project has been selected based on the priorities identified through the local CSS and PEI Community Planning Processes. The CSS Older Adult Workgroup worked in collaboration to review the priority needs of this population and the identify the most essential individual and system level outcomes connected with these needs. Next, local intervention strategies with the greatest likelihood of high impact outcomes were developed. During the strategy identification and development stage, participants reviewed and discussed a variety of sample programs and locally proven practices. The project's overall structure and sub-components are based on a logic model guided by input from local experts and based on research of out-of-county comparison programs that deliver services using a similar approach.

b. The program is likely to achieve the desired PEI outcomes (evidence-based practices, promising practices and/or locally proven practices), particularly among underserved populations to be served. The county will conduct an outcomes evaluation on the program (describe).

This program is likely to achieve desired outcomes. The model of imbedding a Mental Health Specialist into the exam area is being used nationally and has shown great success for large health centers. The model recommended in this project is currently recommended by the Bureau of Primary Care. Outcome data has shown the effectiveness of this model for large community health centers in other communities where many low income ethnic populations are served. In the procurement process, the agency(s) will be asked to describe how they will evaluate the outcomes of these programs.

c. The program is sufficiently developed to carry out with fidelity.

Previous research conducted by the CSS Older Adult Workgroup was augmented by ACBHCS research to ensure that the program designs for the proposed project are sufficiently developed to meet fidelity standards. Programs chosen for review were selected for their histories of success in addressing the community needs and priority outcomes identified through our PEI Community Planning Process. The comparison programs researched for this project include the Mendocino Community Health Clinics and the Mountain Park Health Center in Arizona. Program budgets, resources, partnerships, goals, activities/services, and scale of operations were assessed and adapted to the development of a program design that could be implemented in Alameda County with the resources available. Program management and supervision needs were also assessed.

d. The program is consistent with the PEI Community Needs, Priority Populations and principles.

This program was designed in response to PEI Community Needs, Priority Populations and principals identified by the State and supported by Alameda County's Community Input Process, Planning Panels and Ongoing Planning Council.

6. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

County Mental Health: The Mental Health Specialists will refer those who are eligible for county mental health services and the Referral Specialist will follow-up with the patient to ensure that the patient was able to receive the needed services. Any problems will be followed-up by the Mental Health Specialists.

Other Services: Those who need mental health services and do not quality for county services will be referred to linguistically accessible community mental health programs. Those who need primary care services will be referred to linguistically assessable County or CBO programs.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

This project will link older adults and families to other needed services through the creation of a culturally and linguistically specialized resource guide (in coordination with the Latino and API PEI Projects). This resource guide will be used to inform people of available services, such as food, domestic violence, substance abuse services, counseling and legal resources. The community clinics' Referral Specialists will follow-up with the older adults to ensure that they are able to access the services to which they were referred.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

The infrastructure is currently in place in community clinics and ERs. There are record keeping systems already in place with data information systems. The Referral Specialists are already in place at most community clinics. The community clinics that are selected will already be known and trusted by the community and are already the place that

these populations would go to seek medical, mental health and substance abuse services. These clinics have a history of serving specific populations and meeting the linguistic and cultural needs of their patients. The identified community clinics and ERs will need to demonstrate their commitment through the allocation of staff time and space to meet and coordinate with outreach and education staff for (1) mental health orientation and training and (2) caseload analysis and the identification and referral of identified clients for mental health screening. Through the procurement process, agencies will be required to demonstrate sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes.

7. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

This is project will bring mental health expertise and mental health services to primary care systems (i.e., community clinics and ERs). To underscore and address concerns of stigma as a barrier to seeking assistance, this project will collaborate with the Stigma and Discrimination Reduction Project that is being funded through PEI. Similarly, linkages with programs in underserved ethnic and language communities will be enhanced by collaboration with the Latino, API, South Asian/Afghan, and Native American Projects that are being funded through PEI.

b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

This program will strengthen and build upon local community based mental health and primary care systems by bridging the two realms. This program is designed to serve a large number of people from underserved ethnic and language populations and to make screening for mental health issues an integrated part of the primary care assessment process. In addition the “nesting” of Mental Health Specialists in the primary care exam area will allow for an improved level of communication and sharing of knowledge of intervention and resources. Studies have shown that this type of integration increases the primary care providers’ use of behavioral interventions[12]

c. Describe how resources will be leveraged.

Much of the infrastructure is currently in place for this service. Community health centers and emergency rooms have an established location, which minimizes space costs. Clerical staff time will also be leveraged. Additionally, the Mental Health Specialists will utilize existing waiting room areas, medical records expenses and Referral Specialist

[12] Mynors, Wallace et. al 1995.

and health education staff. The established data management system will also be leveraged to gather patient demographic and utilization data. There will be no costs related to project promotion for clinics, as there are existing patients to whom the universal screening will be administered. Through the procurement process, agencies will be asked to describe their plan for leveraging additional resources and/or funding.

d. Describe how the programs in this PEI project will be sustained.

This project will be sustained by licensed mental health clinicians and/ or psychiatrists supervising direct Mental Health Specialists in Federally Qualified Health Centers (FQHCs), which have the ability to reimburse a portion of their costs on clients' return visits to the clinics. Other costs in this PEI project will be sustained through continued MHSA funding. As part of implementation, ACBHCS will assess potential providers' management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through ongoing MHSA funding.

8. Intended Outcomes

The CSS Older Adult Workgroup worked in collaboration to review the priority needs of this population and then identify the most essential outcomes connected with these needs. Next, local intervention strategies with the greatest likelihood of high impact outcomes were developed.

Component	Individual Outcomes	System/ Program/ Community Outcomes	Proposed Methods/ Measures of Success
A: Latino-Serving Community Clinic B: API-Serving Community Clinic C: Emergency Rooms	• Appropriate and early identification of mental health issues in older adults who frequently use targeted community clinics and emergency rooms • A network of more supportive relationships for older adults • More appropriate and timely mental health services that prevent more disabling conditions and the number of hospitalizations among older adults with a history of frequently using community clinics or ERs	• Increase awareness and recognition of mental health issues amongst primary care professionals • Increase non-stigmatizing screenings for mental health issues and timely referrals by primary care staff • Reduction in stigma of mental health services utilization by older adults • Increase appropriate use of services so that allocation of resources is more cost-effective	• Tracking logs to measure number of mental health screenings per client • Surveys or focus groups to measure change in knowledge/ attitudes • Integration of mental health screening tool with primary care exams • Key informant interviews or focus groups to evaluate program outcomes over time • Decrease number of client-reported mental health issues • Monitoring of hospitalization data

What will be different as a result of the PEI project and how will you know?

Consumers, families and the community will see increased access to mental health services through an increased awareness and recognition of mental health issues amongst primary care professionals. There will be an increase in penetration into the older adult Latino and API communities through the provision of PEI services to older adults shown by a decrease in the number of reported mental health issues. Additionally, both mental and physical health care delivery will be improved through increased collaboration between mental health and primary health care providers.

9. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

The CSS Plan created the Alameda County Wellness, Recovery and Resilience Hub and the Alameda County Family Education and Resource Center (FERC). The Hub will consult with staff and managers of this PEI project to ensure that wellness and recovery practices are embedded in the project's main activities. Staff hired for this project will receive in-service training conducted by the Wellness, Recovery and Resilience Resource Trainers and ongoing support. The FERC will provide direct support, information, and assistance for family members who are engaged with ACBHCS through this and other projects. As a result of these supports, this project will develop its own capacity to orient, guide and support family members.

PEI projects will be oriented to all CSS activities, in addition to all of the ACBHCS non-MHSA programs, so they can develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

The ACBHCS's Workforce, Education and Training (WE&T) planning panel has developed a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community in which we serve. PEI and WE&T programs will partner in areas of staff recruitment and training.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

At this time, no Capital Facilities and Technology funds have been identified for this project.

10. Additional Comments (optional)

N/A.

County: Alameda **PEI Project Name:** 4. Stigma and Discrimination Reduction Campaign **Date:** Draft 08/18/08

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

The PEI Community Planning Process found that consumers face high levels of stigma and discrimination and that Alameda County has very few outreach, education, training and support programs designed to reduce the trauma, suicide risk and other negative outcomes associated with the experience of stigma and discrimination.

This project incorporates strategies identified in ACBHCS 2007 PEI Survey Results. The strategies include community education and outreach delivered by consumers, media campaigns and direct contact between consumers and key groups, such as landlords and employers. The community survey also found that "embarrassment, stigma or discrimination" were among the top five barriers to accessing mental health services.

Reducing stigma and discrimination has been a priority across the mental health field. Internalized and external stigma and discrimination undermine hope, impede community integration and discourage clients from seeking help, all of which are essential for recovery and wellness. In 1998, the California Network of Mental Health Clients (CNMHC) conducted focus groups throughout California to determine how mental health clients define "client culture." Clients self identified as being victims of discrimination and stereotyping more than any other client culture characteristic. The experience of discrimination was the most repeated characteristic of client culture, "Stigma is a pervasive barrier to understanding the gravity of mental illnesses and the importance of mental health." [13]

In October, 2007 Alameda County's clients again conveyed the devastating effects of stigma and discrimination on their lives. During Alameda County's "Breaking the Ties that Bind: Challenging Stigma and Discrimination" Conference, clients completed a Social Inclusion (Discrimination and Stigma Reduction) Proposal Survey and described the inequality they experience, in value, in access, and in relationships. They also highlighted the barriers to recovery, hope, caring, empathy, and social inclusion that are generated by stigma and discrimination. The Survey identified a "multi-faceted consumer operated program targeting employers, housing, schools, criminal justice system, media, faith based agencies and health care professionals" as the primary strategy to combat stigma and discrimination. The PEI Stigma and Discrimination Reduction Campaign is based upon these recommendations.

The Ongoing Planning Council (OPC), the primary stakeholder group for MHSA planning, has identified the reduction of stigma and discrimination as a top priority for local PEI funding.

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI intervention

This project focuses on three areas: (A) Outreach and Education, (B) Media Program and (C) Personal Empowerment and Spirituality. This project, uses direct contact with people with mental illness as the primary

[13] The President's New Freedom Commission on Mental Health *Achieving the Promise: Transforming Mental Health Care in America*

approach to decrease stigma and discrimination and promote community inclusion for people with mental illness. This approach is based upon research conducted by Dr. Patrick Corrigen, from the University of Chicago Center for Psychiatric Rehabilitation, which has proven the contact method successful in changing attitudes and thus behaviors. Dr. Corrigen's research has shown that members of the general public who engage with a person with mental illness as part of an anti-stigma program show significant changes in their attitudes towards mental illness.

This project includes three core components that are described below:

Component A: Outreach and Education

Establish an Outreach, Education and Training Program that will:

a. Provide technical assistance (TA) to reduce stigma and discrimination to other PEI Programs.
b. Develop a Speakers Bureau, designed to educate the public based on outreach to and requests from all community groups, especially individuals and families from underserved and inappropriately served communities. Presentations will be tailored to meet the needs of each targeted community. When presenting to underserved or inappropriately served communities, speakers will represent these communities and be linguistically competent. Whenever possible, these efforts will be coordinated with community-based organizations (CBOs) serving the specific ethnic communities.
c. Form Action Committees to develop anti stigma and discrimination strategies targeting (1) specific "power groups" such as faith based communities; schools; landlords; employers; policy makers; health and mental health systems; the foster care system; the criminal justice system and physical disabilities rights organizations and (2) specific underserved and inappropriately served communities. The Action Committees will be composed of consumers, family members, members of the targeted group and other community members. Action Committees will develop and implement Action Plans specifically tailored for each targeted group. Action Plans may include surveys and the development of specific communication tools. Communication tools will vary by what is deemed most relevant to a particular target group and could include posters, presentations, videos or employer guides.
d. Create a pool of Client Educators will target specific "power groups" and under/inappropriately served communities.
e. Provide on-going education and collaboration with the larger disability community for the purpose of inclusion of mental disabilities in disability rights scope of services.
f. Host an annual conference to target either a "power group" or a specific stigma and discrimination issue.

Component B: Media

Establish a targeted local Media Program that will develop:

a. Stigma and discrimination reduction message(s) that target stakeholder groups, such as “power groups” and under/inappropriately served communities
b. Targeted print anti-stigma materials, such as posters and brochures
c. Local television, radio, and newsprint opportunities to promote positive messages about and images of people with mental illness to specific stakeholder groups, including threshold language groups
d. A local Media Watch Initiative that will identify and respond to negative images of people with mental illness, particularly those that have been targeted towards power groups and under/inappropriately served communities, including threshold language groups
e. A local web site linked to the ACBHCS web site that will include fact sheets, articles, local resources and other targeted local materials developed through the Stigma and Discrimination Reduction Campaign and other MHSA projects
f. Increased number of shows designated for specific stakeholder groups on “Alameda County Mental Health Matters” a public access television program produced by consumers to address mental health issues

Component C: Personal Empowerment and Spirituality

Establish a Personal Empowerment and Spirituality project that will:

a. Expand ‘Wellness Recovery Action Plan (WRAP)’ trainings, which teach participants strategies for self-management and recovery in order to reduce the risk factors associated with trauma, school failure, involvement with law enforcement and suicide. Provide these WRAP trainings in Alameda County’s four threshold languages (Spanish, Vietnamese, Cantonese, and Farsi) and to special population groups including transitional age youth (TAY); parents with young children; older adults; lesbian, gay, bisexual, transgender, queer, questioning and intersexed (LGBTQQI) populations and to the Far East and North regions of Alameda County, which currently do not have WRAP trainings.
b. Expand ‘Telling Our Stories’ trainings which are based on the recuperative power of consumers understanding and telling their stories to reduce internalized and externalized stigma.
c. Expand ‘Pathways to Recovery’ trainings, which guide participants through self-discovery and planning for recovery in key life domains including social, spiritual, educational and vocational.

b. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

This project aims to reduce internalized self stigmatization of persons with mental illness and externalized discrimination faced by those with mental illness from the general population, including "power groups" such as faith based communities, schools, landlords, employers, policy makers, health and mental health systems, the foster care system, the criminal justice system, physical disabilities rights organizations and the media. This project emphasizes outreach to individuals from underserved and inappropriately served ethnic and age groups. The General PEI Planning Panel selected this as an effective strategy to address community needs across age and ethnic groups to impact the outcomes described above.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

Services will be peer-led and provided through one or more CBO(s) with leadership provided through the CBO(s), ACBHCS and a diverse Advisory Board. The service delivery structure will combat stigma and discrimination through consumer contact as well as modeling. Whenever possible, interventions will take place in settings that facilitate access to individuals and families such as schools, other CBOs and community events. This project was developed collaboratively by Peers Envisioning and Engaging in Recovery Services (PEERS), the Alameda County Pool of Consumer Champions (ACPOCC), and the Alameda County Network of Mental Health Clients (ACNMHC). It is expected that each of these organizations, as well as ACBHCS, will be strong organizational partners.

This project will also have an Advisory Board, comprised of a majority of consumers, representing the many consumer run and driven organizations in Alameda County, as well as family members, representatives of different age groups including children and youth, providers, members of "power groups," and members of underserved and inappropriately served populations and residents from geographically diverse areas of Alameda County. It is expected that the Advisory Board's diverse membership will assist in the development of culturally relevant, accessible and innovative approaches to outreach for specific communities.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

Target populations include children, youth, TAY, adults and older adults who have or are at high risk of developing serious mental illness. Many of these individuals will be of special population groups that experience dual discrimination including under and inappropriately served ethnic and cultural groups. The project will also target "power groups" and under and inappropriately served communities throughout Alameda County. It will begin by convening an

Action Committee to target at least one such under or inappropriately served community in the first year of operation. The project will also link to other PEI Strategies that address stigma and discrimination of under and inappropriately served groups.

This project will likely be located in North or Central Alameda County, though outreach, education, media services and empowerment trainings will be provided to all regions.

e. Highlights of new or expanded programs.

Though there are currently a few, limited local activities aimed at reducing stigma and discrimination, efforts have not been as coordinated or as well funded as proposed through the Stigma and Discrimination Reduction Campaign. This comprehensive countywide program is new to Alameda County.

To date, existing local efforts have included an all volunteer, and thus a limited Speakers' Bureau through the Mental Health Board; five weekly WRAP groups through PEERS; a limited public access consumer produced TV program on mental health issues and a 'Telling Our Stories' project. These existing efforts will be expanded under the proposed project, and complemented through the new infrastructure and activities that have been identified as core elements of this comprehensive local campaign.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Program	*Frequency/Duration of Key Activities*
A: Outreach and Education	A minimum of 48 Speakers Bureau events that reach at least 1,200 individuals/families per year
	2-3 new targeted educational campaigns associated with a specific "power group" or under/inappropriately served group developed/implemented per year
	At least one major PR or media product developed per year for the targeted educational campaigns
	At a minimum, four trainings @ year of disability groups to promote the inclusion of mental disabilities in disability rights scope of service.
B: Media	12 new Mental Health Matters TV shows per year
	Expansion or creation of local website (one-time) to address stigma and discrimination and ongoing updates
	Creation (one-time) and implementation (ongoing) of local media watch program
C: Personal Empowerment and Spirituality	80-120 new WRAP trainings to 800-1,400 individuals per year
	30-40 Pathways to Recovery trainings to 300-500 individuals per year
	Three new Telling Our Stories trainings to 30-40 individuals in year one – One Training of Trainers in year one will lead to between 80-120 individuals secondarily trained by these local trainers in subsequent years.
	At least one half of all individuals served by these trainings will be from under/inappropriately served groups including linguistically isolated groups, TAY, families with young children, older adults, LGBTQQI, geographically inaccessible areas, etc.

g. Key milestones and anticipated timeline for each milestone.

Aug. '08 – Dec. '08	Procurement process
Jan. '09 – Mar. '09	Program start-up, which would include recruitment, hiring and training of staff, and program/infrastructure development
Apr. '09	Program implementation on at least one component would start by no later than April 2009

Please note that the three components may have different timelines, and that the implementation for these components may be sequential to address start-up capacity.

4. Programs

Program Title **Stigma & Discrimination Reduction Campaign***	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
A: Outreach and Education (Annual target of individuals and families served: 1,000)	Individuals: 300 Families: 100	Individuals: 75 Families: 25	6 months
B: Media (Annual target of individuals and families served: 14,436)	Individuals: 4,331 Families: 1,443	Individuals: 1,083 Families: 361	6 months
C: Personal Empowerment and Spirituality (Annual target of individuals and families served: 1,200)	Individuals: 338 Families: 112	Individuals: 113 Families: 37	6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED (Annual target of individuals and families served: 15,150)	**Individuals: 4,547** **Families: 1,516**	**Individuals: 1,137** **Families: 375**	

* Please note that there is likely to be overlap between the individuals and families served through these components.

5. Alternate Programs

☒ Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3).

a. The program has been selected based on a logic model (conduct an inclusive community planning process, identify desired PEI outcomes, match an appropriate program, evaluate results and improve programs).

This project has been selected based on the priorities identified through the local PEI Community Planning Process. The General PEI Planning Panel reviewed the priority needs related to stigma and discrimination that were identified through the Community Input Process (i.e., focus groups, community input meetings, a community survey and community reports). The Panel then worked in collaboration to analyze the most essential individual and system level outcomes connected with each of the identified needs. Next, local intervention strategies with the greatest likelihood of high impact outcomes were developed. During the strategy identification and development stage, participants reviewed and discussed the sample programs listed in the PEI resource materials and other locally proven practices. The project's overall structure and sub-components are based on a logic model guided by input from local experts and based on research of local and out-of-county comparison programs that deliver services using a similar approach.

b. The program is likely to achieve the desired PEI outcomes (evidence-based practices, promising practices and/or locally proven practices), particularly among underserved populations to be served. The county will conduct an outcomes evaluation on the program (describe).

The sub-components of this strategy are based on a combination of promising and/or emerging best practices. ACBHCS Administration conducted research on local and out-of-county comparison programs to evaluate program design and any documented outcomes. The comparison programs researched for this project include:

- Listening Well Training for Speakers Bureau in Santa Cruz
- Stamp Out Stigma Speakers Bureau in San Mateo
- OpenMindsOpen Doors Anti-Stigma Campaign in Pennsylvania
- Anti-Stigma Campaign in Boulder, Colorado
- Palmetto Media Watch Program in South Carolina
- City of Reno Website
- You Know Me Alaska Anti-Stigma Campaign
- Mental Health Matters TV Program in Sacramento
- Recovery Innovations of Arizona, Inc.
- Copeland Center WRAP Trainings
- Focus on Recovery (FOR-U) Program in Connecticut

In the procurement process, the agency(s) will be asked to describe how they will evaluate the outcomes of the major subcomponents of this project.

c. The program is sufficiently developed to carry out with fidelity.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the program designs for the proposed sub-components are sufficiently developed to meet fidelity standards. Programs chosen for review were selected for their histories of success in addressing the community needs and priority outcomes identified through our PEI Community Planning Process. Program budgets, resources, partnerships, goals, activities/services, and scale of operations were assessed and adapted to the development of a program design that could be implemented in Alameda County with the resources available. Program management and supervision needs were also assessed.

d. The program is consistent with the PEI Community Needs, Priority Populations and principles.

This program was designed in response to PEI Community Needs, Priority Populations and principals identified by the State and supported by ACBHCS's Community Input Process, Planning Panels and Ongoing Planning Council.

6. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

The primary objective of this effort is reducing stigma and discrimination within the mental health and primary care services, to provide people with mental health issues increased access to mental health services. Stigma associated with mental health issues is seen as a barrier seeking services. In the October 2007 Social Inclusion (Discrimination and Stigma Reduction) Proposal Survey completed by consumers, family members and providers, mental health system administration, professionals, and providers were rated as among the top five groups that demonstrate stigma and discrimination. The project will target anti-stigma and discrimination education towards mental health and primary care system providers, to reduce stigma and create a more welcoming environment, thereby increasing client utilization of these services.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

In addition to accessing traditional mental health services, the reduction of both internalized stigma and external stigma and discrimination will enable people with mental illness and their families to more readily access community resources. These resources include community support groups, as well as educational, employment, housing, domestic/sexual abuse, and faith/culturally-based services. The project's materials will list available community resources, as appropriate.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the budget and program design for this project includes sufficient programs and activities to achieve desired PEI outcomes at the individual/ family, program/system and community levels. Through the procurement process, agencies will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes. Proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

7. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

Major project partners include PEERS, ACPOCC, ACNMHC, the Full-Service Partnerships funded through the MHSA CSS Plan and Alameda County's socialization centers. In addition, the Stigma and Discrimination Reduction Campaign will collaborate with every project funded through PEI: Latino, South Asian/Afghan, Asian/Pacific Islander (API), Native American, TAY, School/Preschool-Based and Older Adult Projects. The project will interface with "power groups." It will also partner with underrepresented and inappropriately served communities, their leaders and institutions. In addition, an Advisory Board will be formed with representation from a diverse array of key stakeholder including consumers, family members, and representatives from "power groups" and under/inappropriately served communities.

b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

In the Social Inclusion (Discrimination and Stigma Reduction) Proposal Survey mentioned earlier, consumers emphasized the lack of equality in access, value, relationships and the legal system as results of stigma and discrimination. If stigma and discrimination are decreased, people with mental illness will more readily access both mental and primary health services. In addition, decreasing the stigmatizing attitudes of mental and primary health providers towards people with mental illness will result in more equal treatment. Like any other group of people, consumers will be treated with respect and their choices will be honored. For example, within the primary health system, physical complaints of mental health consumers will be addressed rather than dismissed as part of their mental illness, which is often the case. Decreasing stigma and discrimination will not only result in better health for people with mental illness, but also a stronger mental and primary health care system.

Training will provide a greater understanding of mental illness among individuals, families and providers. Discussions and engagement of community-based services and the primary care system can mitigate stigma commonly associated with seeking mental health services. It is anticipated that local mental health and primary care organizations will use the project materials to educate themselves about stigma and discrimination related mental illness. For example, the project will develop consumer training modules, which will include consumers telling their stories. Agencies will be able to use these modules for their own staff and their extended communities. WRAP trainings will be developed and offered in threshold languages that will be utilized by existing services. The project will also outreach to existing programs and services in Alameda County to provide anti-stigma and discrimination trainings.

c. Describe how resources will be leveraged.

It is expected that the community partners described under 7a will help distribute the materials, outreach to their respective members to attend educational events and provide in kind support. In kind support includes things such as space, equipment, staff and volunteer time, consultation and referrals. The project will also cultivate similar support from media providers. For example, Comcast currently provides public access television time for a consumer produced program on mental health issues. Agencies will be asked to describe their plan for leveraging additional resources and/or funding during the procurement process.

d. Describe how the programs in this PEI project will be sustained.

The programs in this project will be sustained through continued MHSA funding. As part of implementation, ACBHCS will assess potential providers' management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through ongoing MHSA funding.

8. Intended Outcomes

The General PEI Planning Panel reviewed priority needs relating to stigma and discrimination that were identified through Community Input. The Planning Panel worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to these desired outcomes.

Component	Individual Outcomes	System/ Program/ Community Outcomes	Proposed Methods/ Measures of Success
A. Outreach and Education B. Media C: Personal Empowerment and Spirituality	• Increased social inclusion in the community for those with mental illness • Increased knowledge of social, emotional, and behavioral issues • Increased knowledge of risk and protective factors • Greater use of community resources to promote better mental and physical health • Less prolonged suffering of people with mental illness • Enhanced resilience and protective factors, including hope and self empowerment • Fewer psychiatric hospitalizations, fewer suicides, and fewer arrests/incarcerations from behavior that stems from a mental health issue	• Reduced internalized/externalized stigma and discrimination, particularly among "power groups," under/ inappropriately served communities, and those trained in personal empowerment/spirituality • Increased number of consumers will more readily utilize mental health PEI and other needed services because of the reduction of personal stigma, as well as the reduction of provider/systemic stigma and discrimination • Similarly, others in the community will be more likely to assist persons experiencing mental health issues in accessing mental health and other services after being exposed to anti-stigma educational messages. The mental health and primary care systems will be more consumer friendly and respectful	• Tracking logs to measure number exposed to educational messages in different formats • Surveys or focus groups to measure change in knowledge/ attitudes relating to people with mental illness • Existing evaluation tools to assess level of personal empowerment over time • Key informant interviews or focus groups to evaluate program outcomes over time

What will be different as a result of the PEI project and how will you know?

The goal of this project to move towards "a community where stigma and discrimination toward those with mental health issues no longer exists." Consumers, families and the community will see a reduction in the negative impacts of stigma and discrimination by those with mental illness through increased knowledge of risk and protective factors. This would be demonstrated by the empowerment of people with mental illness and their equal access to education, housing, jobs and community resources. Additionally, there will be an increase in service utilization as measured by a decrease in psychiatric hospitalizations and other negative impacts of stigma and discrimination. Systemically, mental health services and supports will be provided "without fear, loss of freedom, loss of choice, or loss of dignity" through an increase in the level of knowledge of mental health issues and risk factors. The absence or reduction of stigma and discrimination will enhance personal and system wellness and recovery.

9. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

The CSS Plan created the Alameda County Wellness, Recovery and Resilience Hub and the Alameda County Family Education and Resource Center (FERC). The Hub will consult with staff and managers of this PEI project to ensure that wellness and recovery practices are embedded in the project's main activities. Staff hired for this project will receive in-service training conducted by the Wellness, Recovery and Resilience Resource Trainers and ongoing support. The FERC will provide direct support, information, and assistance for family members who are engaged with ACBHCS through this and other projects. As a result of these supports, this project will develop its own capacity to orient, guide and support family members. In addition, this project will collaborate with the full-service partnerships which receive funding under CSS regarding the WRAP, Pathways to Recovery and Listening Well Trainings.

PEI projects will be oriented to all CSS activities, in addition to all of the ACBHCS non-MHSA programs, so they can develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

The ACBHCS's Workforce, Education and Training (WE&T) Planning Panel has developed a comprehensive Consumer Employment Toolkit that includes a number of empowerment trainings for consumers and family members and a focus on job-readiness skills and preparing the workforce for consumer employees. While the WE&T Plan has not yet been approved, key elements of the proposed plan will support this project. As peer trainings and other peer opportunities increase, and as the traditional workforce has more opportunity to work alongside peer providers who self-identify as consumers, stigma and discrimination in the workforce will gradually decrease. PEI and WE&T

programs will partner in areas of staff recruitment and training. In addition, there will be a number of opportunities through WE&T to train the general workforce about mental health stigma and discrimination.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

At this time, no Capital Facilities and Technology funds have been identified for this project.

10. Additional Comments (optional)

N/A.

County: Alameda County **PEI Project Name:** 5. Outreach, Education & Consultation for the Latino Community **Date:** Draft 08/18/08

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s)

During the Community Input Process, disparities in access to mental health services were identified as a need among underserved ethnic and languages populations. In 2000, there were over 312,426 Latinos in Alameda County, which comprised about 26% of Alameda County's population living at or below 200% the Federal Poverty Level (FPL).[14] Current utilization rates demonstrate that existing services for Latinos result in continued disparities for this population. In fact, Latinos are currently served at only one-third the rate of the general population in the current public mental health system.

Barriers to mental health services access for Latinos include:

- Language differences for those with limited English proficiency;
- Lack of information and education about emotional wellness, mental health issues and behavioral health services;
- Existing programs that do not provide well matched services to this population;
- Linguistic specialty programs that are not adequately resourced to meet the needs of the population;
- Stigma, shame and discrimination associated with mental health symptoms and
- Fear of the consequences of seeking help from the public mental health system.

The PEI Community Planning Process revealed that the risk of school failure is particularly acute for Latinos, who have the lowest rate of high school graduation in Alameda County. Due to the large number of Latinos that reside in Alameda County and the disparities in access to services that the Latino population face, the Ongoing Planning Council (OPC), consistently identified this population as a local PEI funding priority.

3. PEI Project Description

a. Description of proposed PEI Intervention

This project employs a strength-based, wellness-focused approach that includes three types of activities described below: (A) Outreach and Education, (B) Mental Health Consultation and (C) Cultural Wellness Practices.

The project staff, *Promotores* and Mental Health Specialists/Consultants, will collaborate to provide the following activities*:*

Component A: Outreach and Education

Outreach and Education activities will be conducted throughout the county to reduce mental health disparities in the Latino population. Activities include psycho-educational workshops, "*placticas*" (discussion groups) and drop-in mutual support groups that address individual and family mental health as well as various wellness topics. These

[14] Census 2000.

activities will be offered in community settings frequented by Latinos, such as childcare settings, schools, faith based organizations and support groups. Special effort will be made to publicize and deliver outreach/education in ways that touch hard-to-reach segments of the community, such as youth at risk for involvement in the criminal justice system, school failure and/or suicide. Home visits will be utilized to reach isolated individuals, such as those at risk for suicide and to include the family in outreach/education services. Educational activities will utilize culturally based learning strategies such as "*dichos*" (proverbs) to provide a culturally familiar paradigm for learning. A bilingual resource guide with community and county mental health services will be developed for community members and community based organizations.

Component B: Mental Health Consultation

Mental Health Consultation will strengthen the skills and capacities of trusted local community leaders, to effectively identify individuals who are in distress and/or trauma exposed, provide education and support, and link distressed individuals to needed services. *Promotores* will provide case management to community members to ensure linkages to appropriate mental health services. Consultation will also include periodic focus groups, *platicas*, or peer consultations in which systematic inquiry is utilized to learn from the community about problems as they emerge and develop effective resolutions. Leaders include public health nurses, childcare workers, teachers, faith based leaders, disability advocates and support group leaders who work with the Latino community. This strategy leverages existing community support structures by identifying a greater number of at-risk individuals than what could be reached by the Mental Health Specialists and *Promotores* alone.

Component C: Cultural Wellness Practices

Examples of a Cultural Wellness Practices include monthly traditional healing/wellness consultations open to the community, which feature the use of an herbalists or "*Curanderos*" (healers) who provide "*limpias*" (cleansings) and other types of healing methods that are meant to address forms of trauma. The Cultural Wellness Practices will be provided through regional single session healing and wellness workshops provided by culturally traditional healers.

Cultural Wellness Practices will be incorporated into outreach and education, consultation and early intervention activities. When early signs or symptoms of emotional distress are disclosed, staff will meet with individuals and families to assess needs and provide brief early intervention services, including techniques to build resiliency, strengthen protective factors and create linkages to culturally appropriate community services. Project staff will also assess needs through a culturally appropriate assessment tool, complete and provide early intervention services to identified individuals and families in one to four visits, then follow and support clients as needed to ensure that linkages have been made.

b. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

This project will address the barriers in access to mental health services for Latinos by providing linguistic and culturally specific services to Alameda County's Latino population.

This project focuses on each of the PEI priority populations: trauma-exposed, individuals experiencing onset of serious psychiatric illness, suicide risk, children and youth in stressed families and at risk of juvenile justice involvement. For Latinos, "trauma-exposed" includes trauma from violence/war in their country of origin, immigration trauma and exposure to community and family violence. "Stressed families" include families experiencing poverty, acculturation stress, substance abuse issues and exposure to domestic or community violence

The desired outcomes of this project are: (1) to build mental health awareness in Latino communities in order to reduce the negative affects of risk factors by developing protective factors and skills, (2) provide resources in familiar community locales and (3) if necessary, provide professional help at the first signs of critical need.

The Underserved Ethnic and Language Populations PEI Planning Panel selected this intervention as an effective strategy for addressing the needs of the Latino Population and impacting the desired outcomes described above.

The use of both professional Mental Health Specialists and *Promotores* are vital to the implementation of the strategy. While the Latino community values the expertise of doctors and psychologists, the community also utilizes *Promotores* to deliver health care services. Thus, consumers and family members will be hired as *Promotores*, as their lived experience allows them to address stigma and discrimination from a personal perspective and model experiences of hope and recovery. *Promotores* and mental health professionals must be bilingual and come from the communities being served. The *Promotores* will provide services and support in community sites frequented by members of the Latino population, such as schools, faith based organizations, childcare sites, senior settings and local healthcare delivery sites.

It is also recommended that an advisory board of consumers, family members and community members meet regularly to provide input and expertise to assist in the development of this project and the delivery of services.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

A community-based organization (CBO) will serve as the lead agency. The project will be delivered county-wide through the collaborative efforts of four organizations, one in each geographical region of Alameda County. According to community input, the organizations must be trusted by Latino community members in each respective region. The lead agency will (1) share best practices across the four organizations and (2) ensure that resources are deployed in the most efficient and cost-effective manner to accomplish the aims of the project. Each organization will hire

Promotores and Mental Health Specialists with work experience in their community and the ability to meet consumers in regional community settings, which include schools, other CBOs and community events. The Latino Best Now consumer training program will be used to recruit consumers who have had substantial training for the *Promotores* positions.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The project will serve Latinos of all ages while ensuring that no less than 51% of the services are directed towards Latinos who are 0-25 years old. Of those served in this project at least 90% will be Latinos. This strategy will also serve Latinos throughout all geographic regions of Alameda County.

In addition to the PEI priority populations this project includes targeted efforts to seek out hard-to-reach subgroups in the Latino community, including:

- Newly arrived immigrant populations
- Isolated, trauma-exposed Latinos
- Older adults, including those who may lack transportation or be homebound
- Transition age youth (TAY aged 16 to 24 years)
- Children ages 0-5 cared for at home and not accessible through childcare centers and Head Start programs.
- Lesbian, gay, bisexual, transgender, queer, questioning and intersex (LGBTQQI) Latinos
- Disabled individuals who are not connected with service providers

e. Description how this intervention is new compared to existing intervention(s) or expands from existing intervention(s) in the County.

The use of Mental Health Specialists and *Promotores* to reach Latinos is a new approach to leverage mental health dollars, as is integration of valued traditional medicine approaches. This project will extend the continuum of services from Latinos who are diagnosed with a mental health condition to Latinos who are in distress and may present early mental health symptoms with no diagnosis. Additionally, this project will provide information to community members; enhance coping skills and resiliency factors.

f. Actions to be performed to carry out the PEI project including frequency or duration of key activities.

PEI Program	Example activities may include:	Frequency / Duration
A. Outreach and Education	Community events	One community-wide event per year
	Home visits	104-520 hours per year
	Psycho-educational workshops	At least one monthly workshop per year
	Support groups	At least 2-6 active support groups per year
B. Mental Health Consultation	Consultation/ Training for community leaders	4-12 trainings, annually
	Early Intervention for individuals and families	1-4 low intensity, brief treatments per individual or family for less than one year
C. Cultural Wellness Practices	Workshops for community	8 workshops per year
	Utilization of cultural wellness practices, as needed	300-625 individuals per year.

g. Key milestones and anticipated timeline for each milestone.

Aug. '08 – Dec. '08	Procurement process
Jan. '09 – Mar. '09	Program start-up, which would include recruitment, hiring, and training of staff, program/infrastructure development, and the formation of partnerships and subcontracts for Cultural Wellness Practices
Apr. '09	Program implementation by no later than April 2009

PEI PROJECT SUMMARY

Form No. 3

4. Programs

Program Title **Outreach, Education & Consultation for the Latino Community***	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
A. Outreach and Education (Annual target of individuals and families served: 1,250)	Individuals: 245 Families: 255	Individuals: 61 Families: 64	6 months
B. Mental Health Consultation (Annual target of individuals and families served: 500)	Individuals: 98 Families: 102	Individuals: 25 Families: 25	6 months
C. Cultural Wellness Practices (Annual target of individuals and families served: 300)	Individuals: 55 Families: 57	Individuals: 18 Families: 20	6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED (Annual target of individuals and families served: 1,250)	**Individuals:** 245 **Families**: 255	**Individuals:**61 **Families**:64	6 months

* Those served by Consultation and Cultural Wellness are usually a subset of those served through Outreach.

5. Alternate Programs

☒ Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3).

a. The program has been selected based on a logic model (conduct an inclusive community planning process, identify desired PEI outcomes, match an appropriate program, evaluate results and improve programs).

This project has been selected based on the priorities identified through the local PEI Community Planning Process. The Underserved Ethnic and Language Populations PEI Planning Panel reviewed the priority needs specific to Latinos that were identified through the Community Input Process (i.e., focus groups, community input meetings, a community survey and community reports). The Panel then worked in collaboration to analyze the most essential individual and system level outcomes connected with each of the identified needs. Next, local intervention strategies with the greatest likelihood of high impact outcomes were developed. During the strategy identification and development stage, participants reviewed and discussed the sample programs listed in the PEI resource materials and other locally proven practices. The project's overall structure is based on a logic model guided by input from local

experts in addressing the needs of underserved communities and based on research of out-of-county comparison programs that deliver services using a similar approach.

b. The program is likely to achieve the desired PEI outcomes (evidence-based practices, promising practices and/or locally proven practices), particularly among underserved populations to be served. The county will conduct an outcomes evaluation on the program (describe).

This project is based on a combination of promising and/or emerging best practices which include modifications of programs listed in the PEI Resource Materials: "A Home-Based Intervention for Immigrant and Refugee Trauma Survivors: Para-professionals Working With High-Risk Mothers and Infants" and "Los Ninos Bien Educados." ACBHCS Administration conducted research on local and out-of-county comparison programs to evaluate program design and any documented outcomes. In the procurement process, the agency(s) will be asked to describe how they will evaluate the outcomes of these programs.

c. The program is sufficiently developed to carry out with fidelity.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the program designs for the proposed project are sufficiently developed to meet fidelity standards. Programs chosen for review were selected for their histories of success in addressing the community needs and priority outcomes identified through our PEI Community Planning Process. Program budgets, resources, partnerships, goals, activities/services, and scale of operations were assessed and adapted to the development of a program design that could be implemented in Alameda County with the resources available. Program management and supervision needs were also assessed. The comparison programs researched for this project include the Latino Health Access Program in Orange County, La Clinica De La Raza in Alameda County, and the Tiburcio Vasquez Health Center - Community Health Education in Alameda County. In the procurement process, the agency(s) will be asked to describe how they will evaluate the outcomes of the major subcomponents of this project.

d. The program is consistent with the PEI Community Needs, Priority Populations and principles.

This project is consistent with the PEI Community Needs, Priority Populations and principles identified by the State and supported by Alameda County's Community Input Process, Planning Panels and Ongoing Planning Council. It emerged from the community it is intended to serve. The Community Input Process not only included reports from the Latino community, but also included the Underserved Ethnic and Languages Planning Panel. This planning panel was responsible for collaborating and creating the strategy based on the needs of the Latino population.

6. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

This strategy will link individuals and families to appropriate mental health services within the ACBHCS system, the primary care system and/or other services offered in the community. When individuals are identified to be in need of and eligible for county mental health services that go beyond the brief therapy that the Mental Health Specialists are able to provide, services will be requested through the Alameda County ACCESS phone referral system and through other sources.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations.

In collaboration with *Promotores,* Mental Health Specialists will refer individuals and family members to appropriate culturally based wellness practices. Community based organizations will use the Spanish Bilingual Resource Guide to help consumers navigate services. An extensive resource guide that will be accessible through the ACBHCS website will be developed and used to link people with needed services. This resource guide will include linguistically capable community support services, community mental health services, self help groups, primary care clinics, medical offices, after school programs, recreational programs, domestic violence programs and other programs that help create a continuum of needed services. Whenever possible, an individual who speaks Spanish will be identified as the primary contact person for Spanish speaking Latinos to encourage their willingness to seek services.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/ family, program/ system, or if applicable, community levels.

A primary goal of this project is to reduce disparities. The project is designed to leverage resources by reaching individuals and families through existing infrastructure in the Latino community. The proposed project needs minimal promotion, since most services will be delivered in organizations that are trusted in the Latino community. The organizations that serve Latinos tend to have the same community and family orientation as the Latino culture. Thus, it is expected that these organizations will welcome and support this project. Partner organizations, such as childcare centers, schools, faith based organizations, disability rights groups and school based health centers will receive and distribute the resource guide through their networks.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the budget and program design for this proposed project includes sufficient policies, management and organizational capacity to develop the program and achieve desired PEI outcomes at the individual/ family, program/system and community levels. Proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes. Agencies will be asked to describe their plan for leveraging additional resources and/or funding during the procurement process.

7. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

This project is best suited as a collaborative with a lead agency to ensure coordination and shared resources. The *Promotores* and Mental Health Specialists will collaborate by sharing expertise and information and providing support to each other. Collaboration with CBOs is vital to this project; local community groups, schools, childcare centers, faith based organizations, community centers and medical offices will serve as service delivery locations. Additionally there will be collaboration with the community through informal networks and word-of-mouth, which serves as a source of important information sharing and outreach.

To underscore and address concerns around stigma as a barrier to seeking assistance, this project will collaborate with the Stigma and Discrimination Reduction Project that is being funded through PEI. Similarly, linkages with programs specific to other underserved ethnic communities and underserved age groups will be enhanced by collaboration with the Asian/Pacific Islander (API), South Asian/Afghan, Native American, School-Based, TAY, and Older Adult Projects that are being funded through PEI.

b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

This project will strengthen and build upon the existing system by identifying individuals and/or families in need of primary care or mental health treatment services. *Promotores* will collaborate with Mental Health Specialists to link consumers to needed referrals and support. Early identification and referral to appropriate community resources will assure that the local community-based mental health and primary care systems will have an opportunity for earlier intervention, which will enhance the effectiveness of those other systems. Mental health and primary care systems may refer their clients to community based, linguistically and culturally appropriate outreach and education events and support groups as resource for PEI.

Training and consultation will engage families and other caregivers through a greater understanding of the relevance of concerns and risk factors for mental illness. Discussions and engagement of community-based services and the primary care system can also mitigate stigma commonly associated with seeking mental health services.

c. Describe how resources will be leveraged.

This project builds on the infrastructure of existing organizations frequented by Latinos. Resources that will be leveraged include space, utilities, volunteers, professional personnel, trust and access to the client population. The consultation aspect of this project leverages the time, collaboration and knowledge of community leaders. Consultation to natural community leaders, including teachers, faith based leaders, disability advocates, support group leaders and health care providers will leverage access to PEI services by building on the opportunities they have to inform, educate, screen and refer. Staff recruitment and training will be leveraged by drawing on several existing resources.

d. Describe how the programs in this PEI project will be sustained.

The components in this project will be sustained through continued MHSA funding. As part of implementation, ACBHCS will assess potential providers' management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through ongoing MHSA funding.

This project leverages resources from both community-based, non-mental health providers at the front end and the county mental health system (i.e. Medi-Cal reimbursement) at the back end through the successful completion of linkages that the strategy will achieve. In addition, as many of the participants will be found through existing community-based programs, any consumer who is eventually linked to the county mental health system will continue to receive a network of support/ wraparound services through the community resources.

8. Intended Outcomes

The Underserved Ethnic and Language Populations PEI Planning Panel reviewed the priority needs specific to Latinos that were identified through the Community Input Process. The Planning Panel worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to these desired outcomes.

Component	Individual Outcomes	System/ Program/ Community Outcomes	Proposed Methods/ Measures of Success
A. Outreach and Education B. Mental Health Consultation C. Cultural Wellness Practices	• Increased access to mental health services • Increased access to early intervention services • Increased knowledge of social, emotional, and behavioral issues • Enhanced resilience and protective factors • Reduced risk factors	• Increased collaboration between organizations • Enhanced capacity of organizations to provide PEI services • Bilingual Latino Resource Guide • Earlier access to mental health services • Increase in number of individuals/ families from underserved populations who receive prevention programs and EI services • Enhanced capacity of organizations to provide PEI services	• Satisfaction survey of participating community organizations and community leaders • Focus groups of individual and family participants • Tracking logs • An advisory board made up of consumers, family community members will review satisfaction surveys, focus group feedback, and other evaluation measurements and direct the efforts of this project to most effectively reach the target population and respond to emerging community issues.

What will be different as a result of the PEI project and how will you know?

Consumers, family members and the community will see a reduction of barriers through increased service utilization in the Latino community. The Outreach and Education components of this project will increase the community's knowledge of the risk factors and symptoms of mental illness. Additionally, the negative impact of risk factors will be reduced as resiliency factors are increased. Moreover, the system will be enhanced through increased collaborations and integration.

9. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

The CSS Plan created the Alameda County Wellness, Recovery and Resilience Hub and the Alameda County Family Education and Resource Center (FERC). The Hub will consult with staff and managers of this PEI project to ensure that wellness and recovery practices are embedded in the project's main activities. Staff hired for this project will receive in-service training conducted by the Wellness, Recovery and Resilience Resource Trainers and ongoing support. The FERC will provide direct support, information, and assistance for family members who are engaged with ACBHCS through this and other projects. As a result of these supports, this project will develop its own capacity to orient, guide and support family members. In addition, this project will collaborate with the full-service partnerships which receive funding under CSS regarding the WRAP, Pathways to Recovery and Listening Well Trainings.

PEI projects will be oriented to all CSS activities, in addition to all of ACBHCS non-MHSA programs, so they can develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

The ACBHCS's Workforce, Education and Training (WE&T) Planning Panel is developing a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect our diverse community. PEI and WE&T programs will partner in areas of staff recruitment and training. Our PEI Latino program will be one of the main avenues of outreach for the WE&T strategies, including targeted financial incentives such as stipends, as well as other approaches to recruit, mentor, and retain Latino and Spanish-speaking professionals in the mental health field. In addition, the Training Plan proposed through WE&T will be exploring issues of cultural competency and wellness practices across cultures.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

At this time, no Capital Facilities and Technology funds have been identified for this project.

10. Additional Comments (optional)

N/A.

PEI PROJECT SUMMARY

Form No. 3

County: Alameda County **PEI Project Name:** 6. Outreach, Education & Consultation for the Asian Pacific Islander Community **Date:** Draft 08/18/08

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

This project addresses the disparities in access to mental health services in the Asian Pacific Islander (API) population of Alameda County. The 2005 and 2007 Asian Community Mental Health Services (ACMHS) and Asian Pacific Psychological Services (APPS) Consumer, Family and Community member Focus Groups and Surveys found that APIs are underserved for cultural reasons, such as shame, stigma and discrimination. Disparities in access to the mental health system include causes related to lack of culturally and linguistically appropriate services and lack of insurance coverage. According to the California Department of Mental Health, APIs in Alameda County are three times less likely to utilize the county mental health system than the general population, with a penetration rate of 5% for APIs compared to 16% for Whites. According to utilization statistics, while 39% of the total population with Serious Emotional Disturbance/Serious Mental Illness (SED/SMI) is unserved, 65% of the API population is unserved.

The most common factors that contribute to these conditions include trauma from violence and war in countries of origin, community violence, historic discrimination, oppression, individual and family-related violence. Also, Transition Age Youth (TAY) in the API community have been largely excluded in current systems of care even though they are at high risk of serious mental illness onset, substance abuse and becoming victims of violence. Due to the lack of cultural competency and linguistic barriers in the current mental health system, API individuals and families often seek assistance from only the most trusted and familiar sources within their respective communities. Yet, the most trusted sources are often not trained to identify, assess and treat the mental health and emotional disturbances of their constituents. Existing mental health programs have not adequately served these communities and most lack the appropriate skills to address needs in a culturally and linguistically competent way. Many individuals in the API community believe that they will be misunderstood by service providers and judged for cultural practices perceived to be different. Research and experience of API mental health providers support the need to intervene as the majority of APIs seeking help have struggled with their illness for years before receiving treatment.

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI Intervention

The proposed three-prongs of the project are: (A) Cultural-Based Outreach and Education, (B) Mental Health Consultation and (C) Cultural Wellness Practices. Each component is designed to address barriers to service as identified by API consumers, family members and other community leaders. This project will also effectively address community mental health needs such as the impact of trauma, suicide risk and reducing the negative affects associated with the first onset of SMI by placing PEI services in sites frequented by API individuals.

This project will ensure that:

(1) API Peer Facilitators will be trained to identify risk factors that contribute to negative outcomes that result from untreated mental health issues such as suicide, involvement in the juvenile justice system and school failure. With existing knowledge and trustful relationships with API communities, a team of Peer Facilitators will outreach to the underserved and unserved API communities and act as cultural brokers and sufficient language capacity to access hard to reach populations; and

(2) API Mental Health Specialists will provide training, mental health expertise and consultation services to Peer Facilitators, community gatekeepers, and CBOs serving the API communities.

The collaborative team of Mental Health Specialists and Peer Facilitators will be located in non-mental health provider organizations in API communities, including primary health clinics with significant API consumers, immigrant and refugee service agencies, API serving youth development programs and other recognized gathering centers for the API community. The team will be supervised by a licensed mental health professional from an established API mental health organization. An advisory group comprised of community representatives, community leaders/elders, consumers and their families will shape the program's design and implementation.

The project consists of the following components:

Component A: Outreach and Education

Outreach and Education will deploy Peer Facilitators with cultural competency and appropriate language capabilities to trusted community sites to: (1) conduct educational workshops on mental health issues and explain common responses to life stressors as conditions that can be ameliorated through mental health services; (2) conduct group psycho-social educational talks where staff will visit existing community gatherings to organize group talks, mutual-support circles and educational and mutual-interest groups; (3) produce Asian language educational materials to be used in the above meetings, at community events and with ethnic media such as newspapers, radio, television and for some communities, websites and (4) produce an API multi-lingual resource referral guide to Alameda County and community services.

Each Peer Facilitator will be equipped with a laptop computer to access materials. Workshop and educational topics will include: (1) general information about mental health issues and symptoms; (2) education for parents to support their children's development; (3) information on the importance of seeking early care, rather than waiting for crisis; (4) stigma reduction messages; (5) how to access mental health and other services; (6) information about mental health issues that impact older adults and (7) resources to help families understand and bridge the cultural/generation gap.

Component B: Mental Health Consultation

Mental Health Consultation will link mental health professionals to trusted leaders, elders and organizations in the API community to identify at-risk individuals before they reach an acute phase, support them in crisis resolution and improve their mental health and functionality. Community-based organizations (CBOs) will receive consultation as partners in the continuum of outreach, referral, screening and assessment. In addition, bilingual and bicultural mental health professionals will ensure culturally competent services and strengthen linkages between community settings and mental health services. On-line consultation to human service providers will also be available and include resources such as reference material and screening tools.

Component C: Cultural Wellness Practices

Consumers and families identified through the consultation process will be able to access Cultural Wellness Practices. In API communities, Cultural Wellness Practices are integrated with the psycho-educational model and may include youth gatherings to enhance cultural protective factors and other culturally-based activities, such as the quilt project, gardening, cultural events and festivals, Polynesian dance, Tai Chi and faith-based events. Models for early intervention will be multi-dimensional and may include family interventions, peer support, afterschool programs, parent classes and support groups, short-term counseling, and therapy by culturally competent providers and practitioners that match the culture and structure of families in the respective communities. Referrals and linkages will be made to established mental health system programs and agencies.

With support and expertise from Mental Health Specialists, Peer Facilitators will work with individuals and families to create personalized wellness plans that include accepted traditional healing practices. Additionally, Peer Facilitators will follow-up in order to support well-being in major life domains and to prevent escalations in mental health crises. Peer Facilitators will identify signs and symptoms of mental health crisis and severe trauma and provide referrals to treatment, if necessary.

To address the needs of individuals and families with complicated multi-dimensional issues and cross-system needs, Peer Facilitators will also facilitate a collaborative process to improve the current system of care to individualize services and provide linkages to traditional and mainstream resources

b. Explain the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

This project will address the disparities in access to mental health services for API individuals and families that are impacted by trauma, suicide risk and first onset of psychosis.

The Underserved Ethnic and Language Populations PEI Planning Panel developed this intervention as an effective project to address the needs of the API population and to achieve desired outcomes, such as increased mental health

awareness in API communities, access to mental health services in a linguistically and culturally competent manner, the provision of resources in familiar community locales and early intervention services when indicated.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

A community-based mental health agency(s) will deliver this model and be guided by wellness and recovery principles that work in partnership with the existing mental health service system and API community providers. A team of Mental Health Specialists and Peer Facilitators will be placed in non-mental health provider organizations, including primary health clinics with significant API consumers, CBOs focused on the needs of API immigrants and refugees, API-serving youth development programs and other recognized gathering centers for the API community. The CBO will employ staff with expertise in mental health and reflect the wide spectrum of age groups, immigrant/refugee cultures and languages that comprise the population. The outreach and education activities will occur in community settings such as schools, other CBOs, and community events.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

This project targets all APIs, many of whom are immigrants and refugees. Several API communities have been identified as underserved. This includes Cambodian, Chinese, Filipino, Japanese, Korean, Lao, Mien, and Vietnamese communities. Some mental health services already exist in these communities and there is a structure of non-mental health providers that can serve as gateway for these mental health services (social services and youth development, CBOs, faith-based, primary health care, traditional healers, etc.). Some of the smaller and emerging API communities have been identified as unserved. For communities such as, Burmese, Mongolian, Thai, Tibetan, Samoan, Tongan and other Pacific Islanders, there is a lack of a formal provider structure for mental health and other needed services, with the exception of faith-based organizations.

The following sub-groups require a deliberate engagement approach, as they are more likely to be overlooked:

- Older adults who lack transportation, tend to be culturally, linguistically and physically isolated.[15]
- Transition age youth (TAY) who have been largely excluded in current systems of care even though they are at highest risk of serious mental health onset, substance abuse, and becoming victims of violence;
- 0-5 children who are harder to reach as many API families rely on relatives as an alternative to day care;
- Stressed families who experience different values and varying levels of acculturation ;
- APIs who are impacted by trauma, suicide risk, and first onset. The most common factors for these conditions include trauma from violence and war in other countries of origin, community violence, historic discrimination and oppression, and individual and family-related violence;
- APIs residing in East and South Alameda County who are often overlooked. While they may be more economically stable, they still lack access to culturally competent services.

The project will be located in Northern region of Alameda County and a team of Peer Facilitators with diverse language capacities will be deployed to the East, Central and South regions of Alameda County for outreach and education, consultation, and cultural wellness services.

According to the 2006 Census, APIs represent 25% of the total population of Alameda County. The Census shows that 23% of APIs are living below 200% of the Federal Poverty Level (FPL). However in disaggregating the API data, some ethnic groups have higher rates of living below 200% of the FPL, including Cambodian (65%), Laotian (52%), Vietnamese (43%), Samoan (45%) and Tongan (50%).

e. Highlights of new or expanded programs.

The use of Mental Health Specialists and Peer Facilitators to reach the underserved and unserved API communities is a new approach to leverage mental health dollars as is integration of valued traditional medicine approaches. To address the disparities in access to mental health services for the underserved and unserved API community, Peer Facilitators will be able to identify and provide referrals to individuals who are in distress and or have early symptoms with no diagnosis. Additionally, this project will provide information to community members; enhance coping skills and resiliency factors.

[15] US DHHS, 1999

f. Actions to be performed and carried out by intervention, including frequency or duration of key activities.

PEI Program	Example activities may include:	Frequency / Duration
A. Outreach Education	Community events	One community-wide event per year
	Home visits	104-520 hours each year
	Psycho-educational workshops	At least one monthly workshop per year
	Support groups	2-6 active support groups each year
B. Mental Health Consultation	Consultation/ Training for community leaders	4-12 trainings, annually
	Early Intervention for individuals and families	1-4 low intensity, brief treatments for less than one year, annually
C. Cultural Wellness Practices	Workshops for community	8 workshops per year
	Referral to cultural wellness practitioner	250-500 individuals

g. Key milestones and anticipated timeline for each milestone.

Aug. ’08 – Dec. ’08	Procurement process
Jan. ’09 – Mar. ’09	Program start-up, which would include recruitment, hiring, and training of staff, program/infrastructure development, and the formation of partnerships and subcontracts for Cultural Wellness Practices
Apr. ‘09	Program implementation by no later than April 2009

PEI PROJECT SUMMARY

Form No. 3

4. Programs

Program Title **Outreach, Education & Consultation for the Asian Pacific Islander Community***	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
A. Outreach and Education (Annual target of individuals and families served: 1,000)	Individuals: 196 Families: 204	Individuals: 49 Families: 51	6 months
B. Mental Health Consultation (Annual target of individuals and families served: 400)	Individuals: 78 Families: 82	Individuals: 20 Families: 20	6 months
C. Cultural Wellness Practices (Annual target of individuals and families served: 250)	Individuals: 46 Families: 48	Individuals: 15 Families: 16	6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED (Annual target of individuals and families served: 1,000)	**Individuals: 196 Families: 204**	**Individuals: 49 Families: 51**	

* Those served by Consultation and Cultural Wellness are usually a subset of those served through Outreach.

5. Alternate Programs

☒ Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3).

a. The program has been selected based on a logic model (conduct an inclusive community planning process, identify desired PEI outcomes, match an appropriate program, evaluate results and improve programs).

This project has been selected based on the priorities identified through the local PEI Community Planning Process. The Underserved Ethnic and Language Populations PEI Planning Panel reviewed the priority needs specific to APIs that were identified through the Community Input Process (i.e., focus groups, community input meetings, a community survey and community reports). The Panel then worked in collaboration to analyze the most essential individual and system level outcomes connected with each of the identified needs. Next, local intervention strategies with the greatest likelihood of high impact outcomes were developed. During the strategy identification and development stage, participants reviewed and discussed the sample programs listed in the PEI resource materials and other locally proven practices. The project's overall structure is based on a logic model guided by input from local

experts in addressing the needs of underserved communities and based on research of out-of-county comparison programs that deliver services using a similar approach.

b. The program is likely to achieve the desired PEI outcomes (evidence-based practices, promising practices and/or locally proven practices), particularly among underserved populations to be served. The county will conduct an outcomes evaluation on the program (describe).

This project is based on a combination of promising and/or emerging best practices, which include modifications of suggested PEI resource materials: Lao Khmu Association: Family Self-Sufficiency Program and Asian Pacific Islander Family Resources Network. ACBHCS Administration conducted research on local and out-of-county comparison programs to evaluate program design and documented outcomes.

For the outreach and education component, the comparison programs researched for this project include the Latino Health Access Program in Orange County, La Clinica De La Raza *Promotores* Program in Alameda County and the Tiburcio Vasquez Health Center in Alameda County. For the mental health consultation and cultural wellness components, the comparison programs researched include the Hume Center in Contra Costa County, the Richmond Area Multi-Services Program in Contra Costa County and the South Asian Mental Health Association in New Jersey. In the procurement process, the agency(s) will be asked to describe how they will evaluate the outcomes of the major subcomponents of this project.

c. The program is sufficiently developed to carry out with fidelity.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the program design is sufficiently developed to meet fidelity standards. Programs chosen for review were selected for their histories of success in addressing the community needs and priority outcomes identified through our PEI Community Planning Process. Program budgets, resources, partnerships, goals, activities/services, and scale of operations were assessed and adapted to the development of a program design that could be implemented in Alameda County with the resources available. Program management and supervision needs were also assessed.

d. The program is consistent with the PEI Community Needs, Priority Populations and principles.

This program was designed in response to PEI Community Needs, Priority Populations and principals identified by the State and supported by Alameda County's Community Input Process, Planning Panels and Ongoing Planning Council. It emerged from the community it is intended to serve. The Community Input Process not only included reports from the API community, but also included the Ethnic/Underserved writing panel. The writing panel was responsible for collaborating and creating the strategy based on the needs of the API population.

6. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI intervention links individual participants who are perceived to need assessment, extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

The project will increase successful linkages to services for API individuals identified through Outreach and Education, Mental Health Consultation, and Cultural Wellness Practices in a number of ways. First, the project views mental health holistically as body, mind and spirit together, which is in line with how API cultures perceive health. Stigma will be reduced when mental health is regarded in this manner. Second, integration of Mental Health Specialists and Peer Facilitators in the API community will promote trust and bonding. With appropriate language and cultural skills, Peer Facilitators will link individuals or families to appropriate mental health services within the county mental health system, the primary care system, and/or other appropriate mental health services offered in the community.

When individuals are identified who are in need of and eligible for county mental health services that go beyond limited brief therapy, the Mental Health Specialists and Peer Facilitators will assist the individual to call and request Alameda County ACCESS phone service.

b. Describe how the PEI intervention links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health and have established or show capacity to establish relationships with at-risk populations; particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention; and basic needs.

Individuals and family members will be linked to other needed services in all three components of the project. It is the primary role of the Peer Facilitator to build bridges and provide participants with culturally appropriate services, integrating newly identified individuals into the existing mental health system and linking them to other services with follow-up. Done in the context of relationship building, Peer Facilitators help individuals/families identify the resources at the community-level, explore and recommend PEI alternatives that fit client language, cultural, and traditional needs.

Community based organizations will use the Bilingual Resource Guide to link consumers to the appropriate services in the county mental health system and the community, as needed.

c. Demonstrate that the PEI intervention includes sufficient policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system, or, if applicable, community levels.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the budget and program design for this proposed project includes sufficient programs and activities to achieve desired PEI outcomes at the individual/ family, program/system and community levels. Through the procurement process, agencies will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes. Proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

Policies to achieve desired PEI outcomes at all levels include: (1) Paraprofessional and professional staff will make joint decisions affecting programs and participants; (2) Participants and their natural supports will drive the process for determining their wellness plans; (3) Community input in shaping the outreach, consultation, and wellness practices.

This strategy leverages resources from both community-based, non-mental health providers at the front end and the county mental health system (i.e. Medi-Cal reimbursement) at the back end through the successful completion of linkages that the strategy will achieve. In addition, as many of the participants will be found through existing community-based programs, any consumer who is eventually linked to the county mental health system will continue to receive a network of support/ wraparound services through the community resources.

7. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care, etc., the partnerships that will be established in this PEI intervention and the roles and activities of other organizations that will be collaborating on this intervention.

In the more established, underserved API communities, trusted partners include community based youth programs, community centers, senior centers, libraries and health clinics.

In the unserved populations described in #4, partners include faith based organizations and leaders such as those that exist in the Burmese, Mongolian, Thai, and Tongan communities. Other partners include elders, recognized leaders and informal parent groups. Outreach and education will take place at cultural fairs and entertainment settings that occur in the unserved communities.

The project will collaborate with trusted partners who have established trust and strong relationships with community members. The Mental Health Specialists will provide professional support and training on mental health issues to the partners.

To underscore and address stigma as a barrier to seeking assistance, this project will collaborate with the Stigma and Discrimination Reduction Project that is being funded through PEI. Similarly, linkages with programs specific to other underserved ethnic communities and underserved age groups will be enhanced by collaboration with the Latino, South Asian/Afghan, Native American, School-Based, TAY, and Older Adult Projects that are being funded through PEI.

b. Describe how the PEI intervention will strengthen and build upon the local community-based mental health and primary care system including community clinics and health centers.

The project will strengthen and build upon the existing API mental health providers and primary care system by increasing early identification of mental health issues and referral to treatment services. Early identification and referral to appropriate community resources will assure that the local community-based mental health and primary care systems will have an opportunity for earlier intervention, which will enhance the effectiveness of those other systems.

Training and consultation will engage families and other caregivers through a greater understanding of the relevance of concerns and risk factors for mental illness. Discussions and engagement of community-based services and the primary care system can also mitigate stigma commonly associated with seeking mental health services.

Staff will work with providers such as those in preschools, child care centers and schools to strengthen their knowledge about the cultural context of the API community and how to identify children with pre-mental health and mental health issues. Other services in traditional settings include program and case consultation and early referrals. Most importantly, the Mental Health Specialists and Peer Facilitators would act as the link between API community members and community leaders.

c. Describe how resources will be leveraged.

This project builds on the established relationships that community based organizations within both the underserved and unserved API communities by building on the infrastructure of organizations frequented by APIs. Resources that will be leveraged include space, utilities, volunteers, professional personnel, trust and access to the client population. The consultation aspect of this project leverages the time, collaboration and resources of community leaders currently serving the API population. Consultation to natural community leaders including teachers, faith based leaders, disability advocates, support group leaders and health care providers will leverage access to PEI services by building on the opportunities they have to inform, educate, screen and refer API community members. Staff recruitment and training will be leveraged by drawing on several existing resources. More importantly, the Outreach and Education component does not require already overworked and underpaid/ unpaid community resources to do anything more, as this project compliments and strengthens outreach and linkage goals.

By linking their participants to culturally competent mental health resources, this project will increase the

effectiveness and outcomes of programs. Agencies will be asked to describe their plan for leveraging additional resources and/or funding in the procurement process.

d. Describe how the programs in this PEI project will be sustained.

The programs in this project will be sustained through continued MHSA funding. As part of implementation, ACBHCS will assess potential providers' management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through ongoing MHSA funding.

8. Intended Outcomes

The Underserved Ethnic and Language Populations PEI Planning Panel reviewed the priority needs specific to APIs that were identified through the Community Input Process. The Planning Panel worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to these desired outcomes.

Component	Individual Outcomes	System/ Program/ Community Outcomes	Proposed Methods/ Measures of Success
A. Outreach and Education B. Mental Health Consultation C. Cultural Wellness Practices	• Increased access to mental health services • Increased access to early intervention services • Increased knowledge of social, emotional, and behavioral issues • Increased knowledge of risk and resilience/ protective factors • Access to culturally competent and linguistically appropriate mental health consultation and wellness practice	• Bilingual API Resource Guide • Increased collaboration between organizations • Enhanced capacity of organizations to provide PEI services • Earlier access to mental health services • Reduced stigma and discrimination • Increased in number of individuals and families identified as needing prevention programs and EI services • Enhanced capacity of organizations to provide PEI services	• Satisfaction survey of participating community organizations and community leaders • Focus groups of individual and family participants • Tracking logs • An advisory board made up of consumers, family community members will review satisfaction surveys, focus group feedback, and other evaluation measurements and direct the efforts of the project to most effectively reach the target population and respond to emerging community issues.

What will be different as a result of the PEI project and how will you know?

Consumers, families and the community will see increased access to culturally and linguistically appropriate services as measured by an increase in utilization rates. Additionally, the project will increase the community's knowledge of risk factors and the impacts of mental illness. Moreover, negative impacts of risk factors will be reduced with increased knowledge of resiliency techniques.

9. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

The CSS Plan created the Alameda County Wellness, Recovery and Resilience Hub and the Alameda County Family Education and Resource Center (FERC). The Hub will consult with staff and managers of this PEI project to ensure that wellness and recovery practices are embedded in the project's main activities. Staff hired for this project will receive in-service training conducted by the Wellness, Recovery and Resilience Resource Trainers and ongoing support. The FERC will provide direct support, information, and assistance for family members who are engaged with ACBHCS through this and other projects. As a result of these supports, this project will develop its own capacity to orient, guide and support family members. In addition, this project will collaborate with the full-service partnerships which receive funding under CSS regarding the WRAP, Pathways to Recovery and Listening Well Trainings.

PEI projects will be oriented to all CSS activities, in addition to all of the ACBHCS non-MHSA programs, so they can develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

b. Describe intended use of Workforce Education and Training funds for PEI projects, if applicable.

The ACBHCS's Workforce, Education and Training (WE&T) planning panel is developing a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect our diverse community. PEI and WE&T programs will partner in areas of staff recruitment and training. The PEI API program will be one of the main avenues of outreach for the WE&T strategies, including financial incentive such as stipends, as well as other approaches to recruit, mentor, and retain API professionals in the mental health field. In addition, the Training Plan proposed through WE&T will be exploring issues of cultural competency and wellness practices across cultures.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

At this time, no Capital Facilities and Technology funds have been identified for this project.

10. Additional Comments (optional)

N/A

PEI PROJECT SUMMARY

Form No. 3

County: Alameda County **PEI Project Name:** 7. Outreach, Education & Consultation for the South Asian & Afghan Community **Date:** Draft 08/18/08

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

The PEI Community Input Process found the South Asian/Afghan community to be a priority population due to a number of factors:

- The growing size of this population in Alameda County
- Linguistic barriers to the receipt of services
- Lack of awareness of and/or physical access to services
- Trauma, due to effects of war, changes in social status due to immigration and/or domestic violence
- Acculturation between generations, which often results in familial stress
- Stigma and discrimination regarding mental health issues both within and outside of their communities.

It is estimated that South Asians are three to four times less likely to be served in the public mental health system when compared to the general population. The service utilization rates among South Asians are a sign of disparities when the most common presenting problems are examined. The PEI Community Input Process revealed that the South Asian community faces high rates of depression, anxiety, domestic violence, adjustment disorder, oppositional and anti-social behaviors, family conflict and developmental disabilities.

A PEI project specific to the South Asian community emerged as a top priority for the Ongoing Planning Council (OPC), the primary stakeholder group for PEI planning.

The 2000 Census report showed that California's South Asian population doubled in the last decade. Within Alameda County, the Asian population, including South Asians, has gone up 180%, making Asians a little over one fifth of Alameda County's population. Additionally, 12% of youth in probation are South Asian. Many South Asians have experienced trauma sometimes resulting in Posttraumatic Stress Disorder (PTSD) and even suicide. Many families face inter-generational conflict and acculturation issues due to immigration paired with limited social supports.

Among South Asians, mental health is rarely seen as a continuum of issues, which may result in a reluctance to seek services and shame associated with psychological issues. Furthermore, there may also be fear regarding confidentiality and a lack of understanding from mental health providers.

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI Intervention

The South Asian project consists of the following three main components: (A) Outreach and Education; (B) Mental Health Consultation and (C) Cultural Wellness Practices. The three components are described in greater detail below:

Component A: Outreach and Education

The goals of Outreach and Education are to reframe mental health care from a pathological to a strength-based, normative perspective in order to reduce the stigma and discrimination faced by this population. Outreach consists of providing information to the South Asian community about the availability of services. Education consists of information about mental illness symptoms, stressors and coping techniques. This component will provide community-based outreach programs and educational workshops delivered by and for the South Asian community. Outreach and Education will occur in culturally appropriate settings, such as community events, faith based organizations, community organizations, primary care settings, juvenile probation and schools.

Component B: Mental Health Consultation

The Mental Health Consultation component will strengthen existing supports and reduce mental health disparities. The Mental Health Specialist/Consultant will train and work with trusted *Community Helpers* and elders in order to better equip them to handle community members' challenges, such as trauma, the first onset of psychosis, risk for school failure and involvement in the criminal justice system. Consultation will occur on three tiers. First, Peer Mentors will be trained by Mental Health Specialists to better outreach and work with the community. Second, Mental Health Specialists will work to educate youth and trusted community leaders through modeling, consultation and co-facilitation as needed. Additionally, Mental Health Specialists will train community based organizations (CBOs), peer mentors, trusted community leaders in providing brief interventions to those at risk for mental illness and to reduce the negative impacts of risk factors.

Component C: Cultural Wellness Practices

The Cultural Wellness Practices will promote early intervention and may consist of referrals to outside agencies or a brief intervention from peer mentors, trained and trusted community members or the Mental Health Specialist. The Cultural Wellness Practices may include activities such as support groups, in-home individual and family visits, and/or mind, body and soul healing practices that will address issues, such as forms of trauma. As the South Asian population consists of diverse communities; the cultural wellness services will mirror the accepted practices in each respective community.

b. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The Underserved Ethnic and Language Populations PEI Planning Panel selected this intervention as an effective program to address the needs of the South Asian population and achieve desired outcomes, such as increased mental

health awareness in South Asian communities, provision of resources in familiar community locales and timely early intervention services when indicated.

This project will provide early interventions to families and individuals from South Asian communities, especially those living below 200% of the Federal Poverty Level (FPL), thus interrupting the progression to more serious issues in a linguistically and culturally appropriate manner.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

The implementation partners include existing community organizations and human service providers, such as schools and primary care settings. The implementation setting will be a linguistically and culturally competent community mental health organization that serves the South Asian population. The project will be based in the Southern region of Alameda County and serve South Asians throughout the entire county. A community mental health organization setting was selected due to its existing relationships with other community services and its established trust within the community.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The target population demographics consist of, but are not limited to, Afghan, Bangladeshi, Indian, Fiji Indian, Nepalese, Pakistani and Iranian ethnic groups. Specifically, services will focus on the following subgroups:

- Trauma exposed individuals of all age levels;
- New immigrants of all ages, especially older adults, transition-age youth (TAY) and children;
- Stressed families, especially families with children ages 0-5;
- Children and youth at risk for school failure;
- Children and youth at risk for involvement with the juvenile justice system; and
- Any individual at risk for the first onset of serious psychiatric mental illness.

All six of the sub-groups will be targeted throughout Alameda County in culturally appropriate settings. For example, children and youth will be outreached in schools; stressed families in neighborhoods with high poverty rates and new immigrants in faith based settings and immigrant neighborhoods.

e. Highlights of new or expanded programs.

This project emphasizes *Community Helpers*, community connections, prevention through multiplication and linguistically and culturally competent providers. The project consists of three major areas of activities, Outreach and

Education, Mental Health Consultation, and Cultural Wellness Practices, that seek to address the target populations and the unique needs of South Asian communities.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Program	Example Actions	Frequency/Duration
A. Outreach and Education	Develop and provide community-based outreach programs	Conduct outreach to 750 families and individuals per year
	Conduct educational workshops to the community and organizations	Conduct 4-12 workshops per year for 1-8 hours per session
B. Mental Health Consultation	Identify and train trusted community leaders	Recruit and train at least two trusted community leaders
	Co-facilitate support groups	Facilitate 6-12 support groups for 1-2 hours per session
C. Cultural Wellness Practices	Provide brief mental health interventions	Provide brief mental health interventions and/or referrals to 188-375 individuals per year

g. Key milestones and anticipated timeline for each milestone.

Aug. '08 - Dec. '08	Procurement process
Jan. '09 - Mar. '09	Program start-up, which would include recruitment, hiring, and training of staff and program/infrastructure development
Apr. '09	Program implementation by no later than April 2009

PEI PROJECT SUMMARY

Form No. 3

4. Programs

Program Title **Outreach, Education & Consultation for the South Asian & Afghan Community***	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
A: Outreach and Education (Annual target of individuals and families served: 750)	Individuals: 147 Families: 153	Individuals: 37 Families: 38	6 months
B: Mental Health Consultation (Annual target of individuals and families served: 300)	Individuals: 59 Families: 61	Individuals: 15 Families: 15	6 months
C: Cultural Wellness Practices (Annual target of individuals and families: 188)	Individuals: 34 Families: 36	Individuals: 12 Families: 12	6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED (Annual target of individuals and families served: 750)	**Individuals:** 147 **Families**:153	**Individuals:** 37 **Families**: 38	1-6 months

* Those served by Consultation and Cultural Wellness are usually a subset of those served through Outreach.

5. Alternate Programs

☒ Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3).

a. The program has been selected based on a logic model (conduct an inclusive community planning process, identify desired PEI outcomes, match an appropriate program, evaluate results and improve programs).

This project has been selected based on the priorities identified through the local PEI Community Planning Process. The Underserved Ethnic and Language Populations PEI Planning Panel reviewed the priority needs specific to South Asians that were identified through the Community Input Process (i.e., focus groups, community input meetings, a community survey and community reports). The Panel then worked in collaboration to analyze the most essential individual and system level outcomes connected with each of the identified needs. Next, local intervention strategies with the greatest likelihood of high impact outcomes were developed. During the strategy identification and development stage, participants reviewed and discussed the sample programs listed in the PEI resource materials and other locally proven practices. The project's overall structure is based on a logic model guided by input from local

experts in addressing the needs of underserved communities and based on research of out-of-county comparison programs that deliver services using a similar approach.

b. The program is likely to achieve the desired PEI outcomes (evidence-based practices, promising practices and/or locally proven practices), particularly among underserved populations to be served. The county will conduct an outcomes evaluation on the program (describe).

This strategy is based on a combination of promising and/or emerging best practices, which include modifications of suggested PEI resource projects. ACBHCS Administration conducted research on local and out-of-county comparison programs to evaluate program design and any documented outcomes. The comparison programs researched for this project include the Hume Center in Contra Costa County, the Richmond Area Multi-Services Program in San Francisco, and the South Asian Mental Health Association in New Jersey. In the procurement process, the agency(s) will be asked to describe how they will evaluate the outcomes of these programs.

c. The program is sufficiently developed to carry out with fidelity.

ACBHCS Administration again conducted research on out-of-county comparison programs to ensure that the program design is sufficiently developed to meet fidelity standards. Programs chosen for review were selected for their histories of success in addressing the community needs and priority outcomes identified through our PEI Community Planning Process. Program budgets, resources, partnerships, goals, activities/services, and scale of operations were assessed and adapted to the development of a program design that could be implemented in Alameda County with the resources available. Program management and supervision needs were also assessed.

d. The program is consistent with the PEI Community Needs, Priority Populations and principles.

This program was designed in response to PEI Community Needs, Priority Populations and principals identified by the State and supported by Alameda County's Community Input Process, Planning Panels and Ongoing Planning Council. It emerged from the community it is intended to serve. The Community Input Process not only included reports from the South Asian community, but also included the Underserved Ethnic and Languages Planning Panel. The writing panel was responsible for collaborating and creating the strategy based on the needs of the South Asian population.

6. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

This project will link individual participants who are perceived to need extended treatment to Alameda County's ACCESS line, which will help the individual obtain information about their benefits status and make referrals to linguistically and geographically appropriate providers. Additionally, the South Asian project provider will be expected to form relationships with non-mental health providers, such as primary care, as well as other more intensive culturally appropriate mental health providers throughout Alameda County.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health had have established or show capacity to establish relationships with at-risk populations particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention and basic needs.

The Mental Health Specialists will be embedded in a CBO that has the capacity to provide services to diverse South Asian populations. Linkages and lines of referral will be created to other mental health providers as well as primary care, schools and other services that may or may not be traditionally mental health focused with the intention of holistic care. Individuals perceived to need further assessment and intensive treatment will be referred to ACCESS, Alameda County's mental health referral line and/or other established mental health providers within their referral network.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system or if applicable, community levels.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the budget and program design for this proposed project includes sufficient programs and activities to achieve desired PEI outcomes at the individual/ family, program/system and community levels. Through the procurement process, agencies will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes. Proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

7. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care etc., the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

The heart of the South Asian project is community collaboration and integration through partnerships with existing CBOs. This project will build on existing connections and bridge gaps between other human service providers. For instance, the Mental Health Specialist and the outreach and education team may provide consultation to a religious leader in the community regarding a recent widow, a primary care staff regarding a patient's medical condition and/or a teacher to address a student's problematic behavior. The intent of collaboration is to train and provide resources to key individuals in the systems that are a part of the community, such as religious settings, health care settings and schools. Additionally, the South Asian project will involve the community at large through the creation of an advisory committee comprised of key South Asian *Community Helpers*, individuals who are trusted by the community, elders, consumers, family members and providers. Additionally, trusted *Community Helpers* and elders will be leveraged by prevention through multiplication. To underscore and address concerns around stigma as a barrier to seeking assistance, this project will collaborate with the Stigma and Discrimination Reduction Project that is being funded through PEI. Similarly, linkages with programs specific to other underserved ethnic communities and underserved age groups will be enhanced by collaboration with the School/Preschool-Based, TAY, Older Adult, Latino, Asian/Pacific Islander (API), and Native American Projects also funded through PEI.

b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care setting including community clinics and health centers.

This PEI component will strengthen and build upon the local community-based mental health and primary care setting by outreaching not only to individuals, but to organizations that serve South Asians in Alameda County. Early identification and referral to appropriate community resources will assure that the local community-based mental health and primary care systems will have an opportunity for earlier intervention, which will enhance the effectiveness of those other systems.

Training and consultation will engage families and other caregivers through a greater understanding of the relevance of concerns and risk factors for mental illness. Discussions and engagement of community-based services and the primary care system can also mitigate stigma commonly associated with seeking mental health services.

c. Describe how resources will be leveraged.

The nature of the outreach, education and consultation will create opportunities to discuss linkages and comprehensive services for mutual clients. Furthermore, the project will collaborate with mental health organizations as well as non-mental health organizations. Referrals will also be made as appropriate through relationship building with community based agencies and Alameda County. In the procurement process, agencies will be asked to describe their plan for leveraging additional resources and/or funding.

d. Describe how programs in this PEI project will be sustained.

The programs in this project will be sustained through continued MHSA funding. As part of implementation, ACBHCS will assess potential providers' management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through ongoing MHSA funding.

8. Intended Outcomes

The Underserved Ethnic and Language Populations PEI Planning Panel reviewed the priority needs specific to South Asians that were identified through the Community Input Process. The Planning Panel worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to these desired outcomes.

Component	Individual Outcomes	System/Program Outcomes	Proposed methods/Measures of Success
A. Outreach and Education B. Mental Health Consultation C. Cultural Wellness Practices	• Increased knowledge of mental illness and services • Enhanced and enriched family functioning • Increased number of individuals that receive culturally appropriate services	• Increased communication and collaboration between organizations • Increased the number of community based leaders • Development a resource guide	• Satisfaction survey of participating community organizations and community leaders • Focus groups of individual and family participants • Tracking logs

What will be different as a result of the PEI project and how will you know?

Consumers, family members and the community will see an increase in access to services through increased service utilization and the development of a resource guide. Additionally, the community will see an increase in the availability of culturally and linguistically appropriate services. Moreover, knowledge of mental health issues and resiliency factors will be increased as a result of outreach and education. The system will be improved through increased collaborations between organizations.

9. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

The CSS Plan created the Alameda County Wellness, Recovery and Resilience Hub and the Alameda County Family Education and Resource Center (FERC). The Hub will consult with staff and managers of this project to ensure that wellness and recovery practices are embedded in the project's main activities. Staff hired for this project will receive in-service training conducted by the Wellness, Recovery and Resilience Resource Trainers and ongoing support. The FERC will provide direct support, information, and assistance for family members who are engaged with ACBHCS through this and other projects. As a result of these supports, this project will develop its own capacity to orient, guide and support family members.

PEI projects will be oriented to all CSS activities, in addition to all of the ACBHCS non-MHSA programs, so they can develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

b. Describe intended use of Workforce, Education and Training funds for PEI projects, if applicable.

The ACBHCS's Workforce, Education and Training (WE&T) planning panel is developing a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect our diverse community. PEI and WE&T programs will partner in areas of staff recruitment and training. The project will be one of the main avenues of outreach for the WE&T strategies, including financial incentive such as stipends, as well as other approaches to recruit, mentor, and retain South Asian professionals in the mental health field. In addition, the Training Plan proposed through WE&T will be exploring issues of cultural competency and wellness practices across cultures.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

At this time, no Capital Facilities and Technology funds have been identified for this project.

10. Additional Comments (optional)

N/A.

PEI PROJECT SUMMARY

Form No. 3

County: Alameda County **PEI Project Name:** 8. Outreach, Education & Consultation for the Native American Community **Date:** Draft 08/18/08

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☒	☒	☒	☒
2. Psycho-Social Impact of Trauma	☒	☒	☒	☒
3. At-Risk Children, Youth and Young Adult Populations	☒	☒		
4. Stigma and Discrimination	☒	☒	☒	☒
5. Suicide Risk	☒	☒	☒	☒

2. PEI Priority Population(s) **Note: All PEI projects must address underserved racial/ethnic and cultural populations.**	**Age Group**			
	Children and Youth	Transition-Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Trauma Exposed Individuals	☒	☒	☒	☒
2. Individuals Experiencing Onset of Serious Psychiatric Illness	☒	☒	☒	☒
3. Children and Youth in Stressed Families	☒	☒		
4. Children and Youth at Risk for School Failure	☒	☒		
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☒	☒		

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

The Community Input Process revealed that Native Americans are an important target population for PEI due to health disparities and gaps in service provision in their communities.

The research shows that Native Americans are unlikely to seek help from the public mental health system due to a lack of provider cultural capacity and the discord between institutional definitions of mental health and the traditional values of the Native American Community. The 2003 U.S. Commission on Civil Rights reported that the health needs of tribal people "lagged 20 to 25 years behind the general population."

The Community Input Process found that Native Americans living in Alameda County faced specific risk factors, including domestic violence, elder abuse, child abuse, anger, family conflict, unresolved grief/loss and suicide risk.. Native Americans face stigma and discrimination within and outside of their communities, especially when one considers the historical context of Native Americans living under colonialism, negative media portrayal and marginalization. Native Americans have been exposed to intergenerational traumatic stress disorder, as a result of isolation, assimilation and marginalization.

According to the 2000 U.S. Census data, there are 23,177 American Indian/Alaska Natives in Alameda County, with 7,164 aged 0-18, 14,758 aged 19-64 and 1,255 aged 65 and older. The Native American population is not only significant; it is also diverse, with many of the 570 federally recognized tribes represented in the Bay Area.

The Community Input Process included a Community Report by the Native American Health Center that summarized data and recommendations from the Native American Community. Data for this Community Report included local epidemiological data, census information, local surveys, focus groups and published research.

The Ongoing Planning Council (OPC), the primary stakeholder group for PEI planning, identified a mental health project specific to the needs of the Native American community as a key strategy for local PEI funding.

3. PEI Project Description: (attach additional pages, if necessary)

a. Description of proposed PEI intervention

In order to address the lack of culturally specific programs that target Native Americans, this project consists of three main components: (A) Outreach and Education; (B) Mental Health Consultation and (C) Community Wellness Practices. The three components were created to overlap with one another and create a continuum of care tailored to Native American community needs. The combination of outreach, community wellness practices and consultation is intended to prevent multiple stressors from escalating to negative consequences such as, involvement in the criminal justice systems and suicide.

Component A: Outreach and Education

The Outreach and Education component will occur during culturally appropriate events, such as Pow-Wows and other community engagements. Pow-Wows will occur at least once per year. The outreach will be conducted by *Natural Helpers*, trained outreach workers who have existing ties with the community, who will help decrease the stigma and discrimination faced by this population and provide access to hard to reach sub-populations. *Natural Helpers* will be trained by a mental health professional. Information booths will be set up at community events to promote positive mental health status, link individuals and families to services by promoting healthy behaviors and providing culturally appropriate information to help demystify and de-stigmatize mental health services.

Component B: Mental Health Consultation

The Mental Health Consultation component will create opportunities for *Natural Helpers* and Mental Health Specialists to co-facilitate trainings. Specifically, the team will partner with school staff to train Youth Peer Mentors that will support youth that are at risk for involvement in the juvenile justice system, school failure and/or suicide. This project intends to engage youth as partners and produce educational materials on healthy behaviors. The consultation team will also provide cultural competence trainings to Native and non-Native American agencies regarding the needs and concerns of Native Americans. Relevant risk factors, such as the early onset of psychosis and the treatment of trauma, will be addressed through the mental health consultation component.

Component B: Cultural Wellness Practices

Cultural Wellness Practices (also known as community wellness practices) consist of a variety of traditional Native American healing practices, such as Naming Ceremonies, Coming of Age Ceremonies, sweat lodges, religious ceremonies, Red Road, access to medicine men/women and talking circles. Talking circles are facilitated community discussion groups with varying topics. This subcomponent is at the heart of the community wellness practices because the topic of discussion and the facilitator come from the community. Community wellness practices are designed to heal Native Americans from historical grief, foster resiliency, restore self-esteem, educate and create a safe space to address community concerns.

b. Explain why the proposed PEI project, including key community need(s), priority population(s), desired outcomes and selected programs address needs identified during the community program planning process.

The Underserved Ethnic and Language Populations PEI Planning Panel selected this intervention as an effective strategy for addressing the needs of the Native American community and achieving desired outcomes such as building mental health awareness in Native American communities, providing resources in familiar community locales and providing timely early intervention services when indicated.

This project creates an infrastructure for culturally appropriate PEI services within the Native American Community. A key component is the early identification of issues related to mental health and appropriate follow-up in order to interrupt the progression to more serious issues by building resiliency and identifying stressors.

c. Implementation partners and type of organization/setting that will deliver the PEI program and interventions. If the setting is a traditional mental health treatment/services site, explain why this site was selected in terms of improved access, quality of programs and better outcomes for underserved populations.

The implementation of this project will occur in a community based organization (CBO) with a history of delivering services to Native Americans. The organization will likely be located in the Northern part of Alameda County. Outreach and Education, Community Wellness Practices and Mental Health Consultation will occur throughout Alameda County. Specifically, events will be held at schools, colleges, within other community based organizations and at community events.

d. Target community demographics, including a description of specific geographic areas and the underserved racial, ethnic and/or cultural populations to be served.

The target demographics of this project include Native American children, youth, transition age youth (TAY), adults and older adults. This project will likely be housed in the Northern region of Alameda County, which is home to a large Native American population. However, the project will reach Native Americans living throughout Alameda County.

e. Highlights of new or expanded programs.

Funding provided specifically for PEI with a focus on Native Americans is a new and innovative project. The project values individuals within the community by turning to them for leadership. The project also involves cross training and mutual learning between youth, elders, community members, health care providers and mental health professionals.

f. Actions to be performed to carry out the PEI project, including frequency or duration of key activities.

Program	Example Actions	Frequency/Duration
A. Outreach and Education	Provide information about services during community events	6-24 times per year/ at least two hours per event
	Sponsor a Pow-Wow	At least one all day event per year
	Inform individuals of culturally appropriate services	Provide information to 600 individuals and families per year
B. Mental Health Consultation	Offer culturally competent training	At least one, four hour training per year
	Train youth peer mentors	At least 8 hours of training per year
C. Cultural Wellness Practices	Sponsor culturally appropriate events, such as talking circles, sweat lodges and various ceremonies	6-12 times per year/ at least two hours per event
	Refer or provide culturally appropriate services	Provide services to 150-300 individuals and families

g. Key milestones and anticipated timeline for each milestone.

Aug. '08 - Dec. '08	Procurement process
Jan. '09 – Mar. '09	Program start-up, which would include recruitment, hiring, and training of staff and program/infrastructure development
Apr. '09	Program implementation no later than April 2009

PEI PROJECT SUMMARY

Form No. 3

4. Programs

Program Title **Outreach, Education & Consultation for the Native American Community***	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
A: Outreach and Education (Annual target of individuals and families served: 600)	Individuals: 118 Families: 122	Individuals: 29 Families: 31	6 months
B: Mental Health Consultation (Annual target of individuals and families served: 240)	Individuals: 47 Families: 49	Individuals: 12 Families: 12	6 months
C: Cultural Wellness Practices (Annual target of individuals and families served: 150)	Individuals: 27 Families: 29	Individuals: 9 Families: 10	6 months
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED (Annual target of individuals and families served: 600)	**Individuals:** 118 **Families**: 122	**Individuals:** 29 **Families**: 31	

* Those served by Consultation and Cultural Wellness are usually a subset of those served through Outreach.

5. Alternate Programs

☒ Please check box if any of the programs listed above are not in the PEI Resource Materials. Attach a narrative providing a rationale for selecting the alternate programs (refer to Instructions for Form No. 3).

a. The program has been selected based on a logic model (conduct an inclusive community planning process, identify desired PEI outcomes, match an appropriate program, evaluate results and improve programs).

This project has been selected based on the priorities identified through the local PEI Community Planning Process. The Underserved Ethnic and Language Populations PEI Planning Panel reviewed the priority needs specific to Native Americans that were identified through the Community Input Process (i.e., focus groups, community input meetings, a community survey and community reports). The Panel then worked in collaboration to analyze the most essential individual and system level outcomes connected with each of the identified needs. Next, local intervention strategies with the greatest likelihood of high impact outcomes were developed. During the strategy identification and development stage, participants reviewed and discussed the sample programs listed in the PEI resource materials and other locally proven practices. The project's overall structure is based on a logic model guided by input from local

experts in addressing the needs of underserved communities and based on research of out-of-county comparison programs that deliver services using a similar approach.

b. The program is likely to achieve the desired PEI outcomes (evidence-based practices, promising practices and/or locally proven practices), particularly among underserved populations to be served. The county will conduct an outcomes evaluation on the program (describe).

The program components of the Native American project are locally proven practices and culturally accepted methods of building resiliency. ACBHCS Administration conducted research on local and out-of-county comparison programs to evaluate program design and any documented outcomes. The comparison programs researched for this project include the Native American Health Center of Santa Clara Valley and the Native American Health Center of San Francisco. In the procurement process, the agency(s) will be asked to describe how they will evaluate the outcomes of these programs.

c. The program is sufficiently developed to carry out with fidelity.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the program design is sufficiently developed to meet fidelity standards. Programs chosen for review were selected for their histories of success in addressing the community needs and priority outcomes identified through our Community Planning Process. Program budgets, resources, partnerships, goals, activities/services, and scale of operations were assessed and adapted to the development of a program design that could be implemented in Alameda County with the resources available. Program management and supervision needs were also assessed.

d. The program is consistent with the PEI Community Needs, Priority Populations and principles.

This program was designed in response to PEI Community Needs, Priority Populations and principals identified by the State and supported by Alameda County's Community Input Process, Planning Panels and Ongoing Planning Council. It emerged from the community it is intended to serve. The Community Input Process not only included reports from the Native American community, but also included the Underserved Ethnic and Languages Planning Panel. The writing panel was responsible for collaborating and creating the strategy based on the needs of the Native American population.

6. Linkages to County Mental Health and Providers of Other Needed Services

a. Describe how the PEI project links individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or other appropriate mental health service providers.

This project will link individual participants who are perceived to need extended treatment to Alameda County's ACCESS line, which will help the individual obtain information about their benefits status and make referrals to linguistically and geographically appropriate providers. Additionally, the project provider will be expected to form relationships with non-mental health providers, such as primary care, as well as other more intensive culturally appropriate mental health providers throughout Alameda County.

b. Describe how the PEI project links individuals and family members to other needed services, including those provided by community agencies not traditionally defined as mental health had have established or show capacity to establish relationships with at-risk populations particularly in the areas of substance abuse treatment; community, domestic or sexual violence prevention and intervention and basic needs.

Through the procurement process, the provider organization will be asked to describe how they will link individuals and family members to non-mental health services such as primary care, as needed, through collaboration and networking abilities. Additionally, this project will allow the community to come forth with issues such as sexual violence, substance abuse treatment, and domestic and community violence by requesting a talking circle from the provider organization. Issues that require extensive treatment will be referred to outside organizations that specialize in intensive services.

c. Demonstrate that the PEI project includes sufficient programs, policies and activities (including leveraged resources) to achieve desired PEI outcomes at the individual/family, program/system or if applicable, community levels.

ACBHCS Administration conducted research on local and out-of-county comparison programs to ensure that the budget and program design for this proposed project includes sufficient programs and activities to achieve desired PEI outcomes at the individual/ family, program/system and community levels. Through the procurement process, agencies will be required to demonstrate that they have sufficient policies, management and organizational capacity in place to develop the program and achieve the desired outcomes. Proposals and bids will be reviewed with specific criteria and benchmarks associated with performance in delivering outcomes.

7. Collaboration and System Enhancements

a. Describe relationships, collaborations or arrangements with community-based organizations, such as schools, primary care etc., and the partnerships that will be established in this PEI project and the roles and activities of other organizations that will be collaborating on this project.

Native American agencies have a history of working collaboratively with schools, criminal justice, child welfare and social services. These service sectors will be encouraged to represent themselves during community events and will be notified of cultural competency trainings. The outreach events will bring providers from diverse sectors together to facilitate networking and introductions. As a result, the system will be enhanced by mutual learning and cross-training between organizations and sectors. To underscore and address concerns around stigma as a barrier to seeking assistance, this project will collaborate with the Stigma and Discrimination Reduction Project that is being funded through PEI. Similarly, linkages with programs specific to other underserved ethnic communities and underserved age groups will be enhanced by collaboration with the School/Preschool-Based, TAY, Older Adult, Latino, Asian/Pacific Islander (API), and South Asian/Afghan Projects also funded through PEI.

b. Describe how the PEI component will strengthen and build upon the local community-based mental health and primary care setting including community clinics and health centers.

This PEI component will strengthen and build upon the local community-based mental health and primary care setting by outreaching not only to individuals, but to organizations that serve Native Americans in Alameda County. Early identification and referral to appropriate community resources will assure that the local community-based mental health and primary care systems will have an opportunity for earlier intervention, which will enhance the effectiveness of those other systems.

Training and consultation will engage families and other caregivers through a greater understanding of the relevance of concerns and risk factors for mental illness. Discussions and engagement of community-based services and the primary care system can also mitigate stigma commonly associated with seeking mental health services.

c. Describe how resources will be leveraged.

The nature of the outreach and consultation will create opportunities to discuss linkages and wraparound services for mutual clients. Furthermore, the project will collaborate with Native and non-Native mental health organizations as well as non-mental health organizations. Referrals will also be made, as appropriate, through relationship building with community based agencies and Alameda County. In the procurement process, agencies will be asked to describe their plan for leveraging additional resources and/or funding.

d. Describe how programs in this PEI project will be sustained.

The programs in this project will be sustained through continued MHSA funding. As part of implementation, ACBHCS will assess potential providers' management and capability to fiscally manage and sustain this program. Fiscal and program monitors will be assigned to the program at start-up. Progress reports and follow-up will be scheduled quarterly to address any emergent problems. Program evaluation will address sustainability and progress in achieving goals. Program success will be sustained through ongoing MHSA funding.

8. Intended Outcomes

The Underserved Ethnic and Language Populations PEI Planning Panel reviewed the priority needs specific to Native Americans that were identified through the Community Input Process. The Planning Panel worked collaboratively to analyze the most essential individual and system level outcomes connected with the identified needs and to develop local strategies that would lead to these desired outcomes.

Programs	Individual Outcomes	System/Program Outcomes	Proposed Methods/Measures of Success
A. Outreach and Education B. Mental Health Consultation C.Community Wellness Practices	• Increased knowledge of mental health services • Increased access to early intervention services • Cultural competency trainings • Increased protective factors and resiliency	• Increased collaboration between organizations • Increased opportunity for information exchange • Increased awareness of appropriate practices • Increased access to culturally appropriate care	• Satisfaction survey of participating community organizations and community leaders • Focus groups of individual and family participants • Tracking logs

What will be different as a result of the PEI project and how will you know?

Consumers, family members and the community will see an increased access to mental health providers in addition to increased options for accessing traditional healing practices as measured by increased referrals and utilization of both mental and physical health services. Moreover, negative consequences of risk factors will be

reduced with an increase in service utilization. Also, the mainstream healthcare system will become more knowledgeable about the needs of Native Americans in Alameda County through the Mental Health Consultation component of the project through increased cultural competency trainings and collaborations.

9. Coordination with Other MHSA Components

a. Describe coordination with CSS, if applicable.

The CSS Plan created the Alameda County Wellness, Recovery and Resilience Hub and the Alameda County Family Education and Resource Center (FERC). The Hub will consult with staff and managers of this project to ensure that wellness and recovery practices are embedded in the project's main activities. Staff hired for this project will receive in-service training conducted by the Wellness, Recovery and Resilience Resource Trainers and ongoing support. The FERC will provide direct support, information, and assistance for family members who are engaged with ACBHCS through this and other projects. As a result of these supports, this project will develop its own capacity to orient, guide and support family members.

PEI projects will be oriented to all CSS activities, in addition to all of the ACBHCS non-MHSA programs, so they can develop a seamless referral system to additional resources for individuals identified as requiring more intensive mental health services.

b. Describe intended use of Workforce, Education and Training funds for PEI projects, if applicable.

The ACBHCS's Workforce, Education and Training (WE&T) planning panel is developing a series of Career Pathways strategies to diversify the mental health workforce to more closely reflect the community we serve. PEI and WE&T programs will partner in areas of staff recruitment and training. Our project will be one of the main avenues of outreach for the WE&T strategies, including targeted financial incentives such as stipends, as well as other approaches for the purpose of recruiting, mentoring, and retaining Native American professionals in the mental health field. In addition, the Training Plan proposed through WE&T will be exploring issues of cultural competency and wellness practices across cultures.

c. Describe intended use of Capital Facilities and Technology funds for PEI projects, if applicable.

At this time, no Capital Facilities and Technology funds have been identified for this project.

10. Additional Comments (optional)

N/A.

ALAMEDA COUNTY

Project Budget Narrative

Please note that the project budgets in the preceding budget worksheets represent a 6-month estimated budget for fiscal year 08/09 that include some one-time costs for project start-up. The expenses described in the PEI line items are for allowable expenses under PEI. The annualized project budgets are listed in Table 4 below.

Table 4: Annualized PEI Project Budgets

PEI Project	Annualized Budget
1.A. School-Based Mental Health Consultation in Preschools	$212,632
1.B. School-Based Mental Health Consultation in Elementary & Middle Schools	$528,015
1.C. School-Based Mental Health Consultation in High Schools	$289,546
2. Early Intervention for the Onset of First Psychosis & SMI Among TAY	$1,143,890
3.A. Mental Health-Primary Care Integration for Latino Older Adults	$282,837
3.B. Mental Health-Primary Care Integration for API Older Adults	$282,837
3.C. Mental Health-Primary Care Integration for Older Adults at ERs	$167,478
4. Stigma & Discrimination Reduction Campaign	$1,171,501
5. Outreach, Education & Consultation for the Latino Community	$713,654
6. Outreach, Education & Consultation for the Asian Pacific Islander Community	$605,250
7. Outreach, Education & Consultation for the South Asian/Afghan Community	$534,856
8. Outreach, Education & Consultation for Native American Community	$274,582
TOTAL:	**$6,207,078**

Project Budgets by Age Group

100% of the annualized budgets for Projects 1 and 2 will be directed towards children, youth and transition-age youth age 0-25 years. In addition, 49% of the annualized budget for Projects 3 and 4, 56% of the budget for Project 5, 46% of the budget for Project 6, 44% of the budget for Project 7, and 33% of the budget for Project 8 will be directed towards those age 0-25 years in accordance with the percentage of these populations shown as being 25 years or younger through the 2000 US Census. This means that the amount directed towards children, youth and transition-age youth is 55% of the total annualized PEI project budget, well over the 51% threshold required by the PEI Guidelines.

General Budget Assumptions

The Project Budget is based on the State's approval of Prevention & Early Intervention Plan by September 2008, thereby starting RPF process in October 2008 and projects operational in January 2009. The following are general budget assumptions used throughout all the PEI budgets. Any exceptions to these assumptions are noted under specific project budgets.

A. Expenditures

1. Personnel Expenditures

Budget for positions in county operated projects are based on FY 08-09 Salary & Wage Sheets. FY 08-09 benefit rate is 49.4%.

Budget for positions in projects to be contracted to Mental Health Community Based Organization are based on an average salaries and benefits of existing community based program budgets. The benefit rate was also an average of existing contracted programs which amounted to 30.0%.

2. Operating Expenditures

Facility Costs – Budget estimates were based on a monthly rate of $2.31 sq ft and an average of 250 sq ft per position. Some adjustments were made for rent depending on the type of facility being leased.

Other Operating Expenses – Budget estimates are based on an average cost of 20% of Salaries & Benefits, plus, an additional 14% for Administrative Overhead.

3. Subcontracts/Professional Services

Each project developed Subcontracts/Professional Services individually based on the unique operation of the project. See notes under each program.

4. Total Proposed PEI Project Budget

Total of Salaries & Benefit, Operating Expenditures and Subcontract/Professional Services.

B. Revenue

FY 08-09 revenue budgets associated with productivity (Medi-cal FFP, Medicare, Patient Fees, Patient Insurance and State General Funds (EPSDT)) are based on estimated number of eligible client to be served.

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1.A. School-Based Mental Health Consultation in Preschools

Budget assumptions were developed by reviewing best practices of local and out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 0.25 FTE Clinical Supervisor
- 0.25 FTE Administrative Assistant
- 1.5 FTE Mental Health Consultant

No specific additional startup costs were included, but assumption is made that there could be recruitment, furniture and computer costs. Medi-Cal Administrative Activities (MAA) and Medi-Cal FFP totaling $19,347 would be generated by this project. In-Kind contribution of $6,930 for space is included.

1.B. School-Based Mental Health Consultation in Elementary & Middle Schools

Budget assumptions were developed by reviewing best practices of local and out-of-County comparison programs. This project will be operated by the County.

The budget assumptions are based on the following preliminary staffing for the proposed project:

- 0.3 FTE Clinical Supervisor
- 3.0 FTE Clinical Case Managers

No specific additional startup costs were included, but assumption is made that there could be recruitment, furniture and computer costs. Medi-Cal Administrative Activities (MAA) totaling $7,221 would be generated by this project. In-Kind contribution of $11,851 for space is included.

1.C. School-Based Mental Health Consultation in High Schools

Budget assumptions were developed by reviewing best practices of local and out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 2.0 FTE Clinical Case Managers

No specific additional startup costs were included, but assumption is made that there could be recruitment, furniture and computer costs. Medi-Cal Administrative Activities (MAA) totaling $1,879 would be generated by this project. In-Kind contribution of $31,024 for 0.25 FTE clinical supervisor and space is included.

2. Early Intervention for the Onset of First Psychosis & SMI Among TAY

Budget assumptions were developed by reviewing best practices of out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 1.0 FTE Executive Director/Outreach Coordinator
- 1.0 FTE PhD Clinical Director/Evaluation/EPB
- 0.5 FTE Psychiatrist
- 0.5 FTE RN Family & Group Specialist
- 2.0 FTE LCSW/MFT Clinical, Family & Group
- 1.5 FTE Family Resource Specialist
- 1.0 FTE Consumer Resource Specialist
- 1.0 FTE Supported Employment & Education Specialist
- 0.4 FTE Data & Media Analyst
- 1.0 FTE Secretary/Office Manager

Subcontracts/Professional Services include a stipends for TAY Advisory Board. No specific additional startup costs were included, but assumption is made that there could be recruitment, furniture, tenant improvement, computer costs and other startup costs. Medi-Cal Administrative Activities (MAA) and Medi-Cal FFP totaling $228,172 would be generated by this project. No In-Kind contribution was included.

3.A. Mental Health-Primary Care Integration for Latino Older Adults

Budget assumptions were developed by reviewing best practices of out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 0.25 FTE Psychiatrist
- 1.0 FTE Psych Nurse Practitioner
- 1.0 FTE Licensed Clinical Social Worker

- 0.5 FTE Administrative Specialist
- 0.5 FTE Community Outreach Worker
- 0.5 FTE Benefits Advocate

Additional startup costs of $121,000 were included for implementation of information system, training, training materials including translation, computers, furniture and recruitment. Medi-Cal FFP would be generated by this project in the amount of $58,849. No In-Kind contribution was included.

3.B. Mental Health-Primary Care Integration for API Older Adults

Budget assumptions were developed by reviewing best practices of out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 0.25 FTE Psychiatrist
- 1.0 FTE Psych Nurse Practitioner
- 1.0 FTE Clinical Social Worker (LCSW)
- 0.5 FTE Administrative Specialist
- 0.5 FTE Community Outreach Worker
- 0.5 FTE Benefits Advocate

Additional startup costs of $121,000 were included for implementation of information system, training, training materials including translation, computers, furniture and recruitment. Medi-Cal FFP would be generated by this project in the amount of $58,849. No In-Kind contribution was included.

3.C. Mental Health-Primary Care Integration for Older Adults at ERs

Budget assumptions were developed by reviewing best practices of out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 2.0 FTE Psych Social Worker

Additional startup costs of $7,000 were included for computers, furniture and recruitment. Medi-Cal FFP would be generated by this project in the amount of $34,143. No In-Kind contribution was included.

4. Stigma & Discrimination Reduction Campaign

Budget assumptions were developed by reviewing best practices of local and out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

Management & Oversight

- 0.25 FTE Executive Director
- 1.0 FTE Campaign Director
- 1.0 FTE Administrative Assistance
- 1.0 FTE Bookkeeper
- 1.0 FTE County Stigma & Discrimination Liaison

Outreach

- 1.0 FTE Outreach, Education & Training Director
- 1.0 FTE Speakers Bureau Coordinator

- 1.0 FTE Outreach Specialist

Media

- 1.0 FTE Media Project Director
- 0.5 FTE Media Watch Director
- 0.5 FTE Website Manager

Spirituality

- 1.0 FTE Personal Empowerment & Spirituality Director
- 1.0 FTE Administrative Assistant
- 1.0 FTE Spirituality Coordinator

Subcontracts/Professional Services include a professional services contract for consultant for start up consultation, stipends for WRAP and Pathways to Recovery trainers, contract for Alameda Mental Matter coordinator, stipends for Advisory Board, Speakers Bureau, community organizers, trainers, Advisory Action Team, and Mental Health Matters, website development and annual fee, DVD production, travel to trainings. Additional startup costs of $416,980 were included for consultation and program design, website development, and training. But an assumption is made that there could be recruitment, furniture, tenant improvement, computer costs and other startup costs. No revenue would be generated by this program. No In-Kind contribution was included.

5. Outreach, Education & Consultation for the Latino Community

Budget assumptions were developed by reviewing best practices of local and out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 0.5 FTE Program Supervisor
- 0.25 FTE Administrative Assistant
- 0.5 FTE Outreach Supervisor
- 1.5 FTE Mental Health Specialist
- 4.0 FTE Promoter (8 Positions/0.5 FTE each)

Subcontracts/Professional Services include a professional services contract for Cultural Wellness Practices. Additional startup cost of $20,000 was included for development of a Bilingual Resource Guide, Computers and IT assistance. And an assumption was made that there could be recruitment, furniture, tenant improvement, computer costs and other startup costs. No revenue would be generated by this program. In-Kind contribution of $1,000 for space is included.

6. Outreach, Education & Consultation for the Asian Pacific Islander Community

Budget assumptions were developed by reviewing best practices of local and out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 0.25 FTE Program Supervisor
- 0.25 FTE Administrative Assistant
- 0.5 FTE Outreach Supervisor
- 1.5 FTE Mental Health Specialist (3 positions/0.5 FTE each)
- 3.0 FTE Promoter (6 positions/0.5 FTE each)

Subcontracts/Professional Services include a professional services contract for Cultural Wellness Practices. Additional startup cost of $20,000 was included for development of a Bilingual Resource Guide, Computers and IT assistance. And an assumption was made that there could be recruitment, furniture, tenant improvement, computer costs and other startup costs. No revenue would be generated by this program. In-Kind contribution of $1,000 for space is included.

7. Outreach, Education & Consultation for the South Asian/Afghan Community

Budget assumptions were developed by reviewing best practices of local and out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 0.5 FTE Program Supervisor
- 0.25 FTE Administrative Assistant
- 0.33 FTE Outreach Supervisor
- 2.0 FTE Mental Health Specialist

Subcontracts/Professional Services include a professional services contract for Cultural Wellness Practices. Additional startup cost of $115,000 was included for development of a Bilingual Resource Guide, Transportation Van, Computers, IT assistance, and First Year Evaluation. And an assumption was made that there could be recruitment, furniture, tenant improvement, computer costs and other startup costs. No revenue would be generated by this program. In-Kind contribution of $1,000 for space is included.

8. Outreach, Education & Consultation for Native American Community

Budget assumptions were developed by reviewing best practices of local and out-of-County comparison programs. The budget assumptions are based on the following preliminary staffing for the proposed project:

- 0.1 FTE Program Supervisor
- 0.5 FTE Mental Health Specialist
- 2.0 FTE Peer Counselors

Subcontracts/Professional Services include a professional services contract for Cultural Wellness Practices and stipends for peer mentors. Additional startup cost of $45,000 was included for development of a Transportation Van and Computers. And an assumption was made that there could be recruitment, furniture, tenant improvement, computer costs and other startup costs. Revenue from Pow-wow vendor space rental of $800 was included in budget. No In-Kind contribution was included.

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

1A. Mental Health Consultation in Schools/Preschools - Preschool and Childcare Sites

County Name: Alameda Date: 8/18/08

PEI Project Name: 3. Children and Youth in Stressed Families

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	250
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	250
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
0.25 FTE Clinical Supervisor	$0	$11,250	$11,250
1.5 FTE MH Consultant	$0	$52,500	$52,500
0.25 FTE Administrative Assistant	$0	$4,688	$4,688
b. Benefits and Taxes @ % 30%	$0	$20,531	$20,531
c. Total Personnel Expenditures	$0	$88,969	$88,969
2. Operating Expenditures			
a. Facility Cost	$0	$6,930	$6,930
b. Other Operating Expenses	$0	$29,610	$29,610
c. Total Operating Expenses	$0	$36,540	$36,540
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$0	$0
4. Total Proposed PEI Project Budget	$0	$125,509	$125,509
B. Revenues (list/itemize by fund source)			0
MAA	$0	$3,311	$3,311
Medi-Cal FFP	$0	$16,036	$16,036
		$0	$0
1. Total Revenue	$0	$19,347	$19,347
5. Total Funding Requested for PEI Project	$0	$106,162	$106,162
6. Total In-Kind Contributions	$0	$6,930	$6,930

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

1A. Mental Health Consultation in Schools/Preschools - Elementary & Middle Schools

County Name: Alameda Date: 8/18/08

PEI Project Name: 4. Children and Youth at Risk for School Failure

Provider Name (if known):

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	1,500
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	1,500
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
0.3 FTE Clinical Supervisor	$0	$19,649	$19,649
3.0 FTE Clinical Case Manager	$0	$120,132	$120,132
	$0	$0	$0
b. Benefits and Taxes @ % 49%	$0	$68,493	$68,493
c. Total Personnel Expenditures	$0	$208,274	$208,274
2. Operating Expenditures			
a. Facility Cost	$0		$0
b. Other Operating Expenses	$0	$66,714	$66,714
c. Total Operating Expenses	$0	$66,714	$66,714
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$0	$0
4. Total Proposed PEI Project Budget	$0	$274,988	$274,988
B. Revenues (list/itemize by fund source)			0
MAA	$0	$7,221	$7,221
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$7,221	$7,221
5. Total Funding Requested for PEI Project	$0	$267,767	$267,767
6. Total In-Kind Contributions	$0	$11,851	$11,851

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

1A. Mental Health Consultation in Schools/Preschools - High Schools

County Name: Alameda Date: 8/18/08

PEI Project Name: 4. Children and Youth at Risk for School Failure

Provider Name (if known):

Intended Provider Category: PreK-12 school

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	3,500
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	3,500
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
			$0
2.0 FTE MH Consultants	$0	$70,000	$70,000
	$0	$0	$0
b. Benefits and Taxes @ % 30%	$0	$21,000	$21,000
c. Total Personnel Expenditures	$0	$91,000	$91,000
2. Operating Expenditures			
a. Facility Cost	$0		$0
b. Other Operating Expenses	$0	$28,281	$28,281
c. Total Operating Expenses	$0	$28,281	$28,281
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$0	$0
4. Total Proposed PEI Project Budget	$0	$119,281	$119,281
B. Revenues (list/itemize by fund source)			0
MAA	$0	$1,879	$1,879
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$1,879	$1,879
5. Total Funding Requested for PEI Project	$0	$117,402	$117,402
6. Total In-Kind Contributions	$0	$31,024	$31,024

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

2. Early Intervention for the Onset of First Psychosis & SMI Among TAY

County Name: Alameda Date: 8/18/08

PEI Project Name: 2. Individuals Experiencing Onset of Serious Psychiatric Illness

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	350
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	350
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
1.0 FTE Exec Director/Outreach Coordinator	$0	$57,500	$57,500
1.0 FTE PhD Clinical Dir/Evaluation/EPB	$0	$60,000	$60,000
0.5 FTE Physician/Psychiatrist	$0	$45,000	$45,000
0.5 FTE RN Family & Group Specialist	$0	$22,500	$22,500
2.0 FTE LCSW/MFT Clinical, Family & Group	$0	$70,000	$70,000
1.5 FTE Family Resource Specialist	$0	$30,000	$30,000
1.0 FTE Consumer Resource Specialist	$0	$20,000	$20,000
1.0 FTE Supported Employment & Education Spec	$0	$25,000	$25,000
0.4 FTE Data & Media Analyst	$0	$16,000	$16,000
1.0 FTE Secretary/Office Manager	$0	$18,750	$18,750
b. Benefits and Taxes @ % 30%	$0	$109,425	$109,425
c. Total Personnel Expenditures	$0	$474,175	$474,175
2. Operating Expenditures			
a. Facility Cost	$0	$41,580	$41,580
b. Other Operating Expenses	$0	$167,876	$167,876
c. Total Operating Expenses	$0	$209,456	$209,456
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
TAY Advisory Board Stipends	$0	$2,400	$2,400
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$2,400	$2,400
4. Total Proposed PEI Project Budget	$0	$686,031	$686,031
B. Revenues (list/itemize by fund source)			0
Medi-Cal FFP	$0	$96,937	$96,937
MAA	$0	$8,575	$8,575
		$0	$0
1. Total Revenue	$0	$105,512	$105,512
5. Total Funding Requested for PEI Project	$0	$580,519	$580,519
6. Total In-Kind Contributions	$0	$0	$0

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

3. Mental Health-Primary Care Integration for Older Adults - Latino-Serving Community Clinic

County Name: Alameda Date: 8/18/08

PEI Project Name: 1. Disparities in Access to Mental Health Services

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	43
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	43
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
0.25 FTE Psychiatrist	$0	$18,563	$18,563
1.0 FTE Psych Nurse Practitioner	$0	$47,781	$47,781
0.5 FTE Administrative Specialist	$0	$13,174	$13,174
1.0 FTE Marriage & Family Counselor	$0	$26,388	$26,388
0.5 FTE Community Outreach Worker	$0	$8,037	$8,037
0.50 FTE Benefits Advocate	$0	$10,300	$10,300
b. Benefits and Taxes @ % 34%	$0	$21,121	$21,121
c. Total Personnel Expenditures	$0	$145,364	$145,364
2. Operating Expenditures			
a. Facility Cost	$0	$20,790	$20,790
b. Other Operating Expenses	$0	$133,992	$133,992
c. Total Operating Expenses	$0	$154,782	$154,782
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$0	$0
4. Total Proposed PEI Project Budget	$0	$300,146	$300,146
B. Revenues (list/itemize by fund source)			0
Medi-Cal FFP	$0	$58,849	$58,849
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$58,849	$58,849
5. Total Funding Requested for PEI Project	$0	$241,297	$241,297
6. Total In-Kind Contributions	$0	$0	$0

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

3. Mental Health-Primary Care Integration for Older Adults - API-Serving Community Clinic

County Name: Alameda Date: 8/18/08

PEI Project Name: 1. Disparities in Access to Mental Health Services

Provider Name (if known):

Intended Provider Category: Mental Health Treatment/Service Provider

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	43
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	43
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
0.25 FTE Psychiatrist	$0	$18,563	$18,563
1.0 FTE Psych Nurse Practitioner	$0	$47,781	$47,781
0.5 FTE Administrative Specialist	$0	$13,174	$13,174
1.0 FTE Marriage & Family Counselor	$0	$26,388	$26,388
0.5 FTE Community Outreach Worker	$0	$8,037	$8,037
0.50 FTE Benefits Advocate	$0	$10,300	$10,300
b. Benefits and Taxes @ % 34%	$0	$21,121	$21,121
c. Total Personnel Expenditures	$0	$145,364	$145,364
2. Operating Expenditures			
a. Facility Cost	$0	$20,790	$20,790
b. Other Operating Expenses	$0	$133,992	$133,992
c. Total Operating Expenses	$0	$154,782	$154,782
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$0	$0
4. Total Proposed PEI Project Budget	$0	$300,146	$300,146
B. Revenues (list/itemize by fund source)			0
Medi-Cal FFP	$0	$58,849	$58,849
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$58,849	$58,849
5. Total Funding Requested for PEI Project	$0	$241,297	$241,297
6. Total In-Kind Contributions	$0	$0	$0

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

3. Mental Health-Primary Care Integration for Older Adults - Ers

County Name: Alameda Date: 8/18/08

PEI Project Name: 1. Disparities in Access to Mental Health Services

Provider Name (if known):

Intended Provider Category: County Agency

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	23
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	23
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
2 FTE Psych Social Workers	$0	$70,349	$70,349
	$0	$0	$0
	$0	$0	$0
b. Benefits and Taxes @ % 45%	$0	$31,587	$31,587
c. Total Personnel Expenditures	$0	$101,936	$101,936
2. Operating Expenditures			
a. Facility Cost	$0	$6,930	$6,930
b. Other Operating Expenses	$0	$16,015	$16,015
c. Total Operating Expenses	$0	$22,945	$22,945
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
	$0	$0	$0
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$0	$0
4. Total Proposed PEI Project Budget	$0	$124,881	$124,881
B. Revenues (list/itemize by fund source)			0
Medi-Cal FFP	$0	$34,143	$34,143
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$34,143	$34,143
5. Total Funding Requested for PEI Project	$0	$90,738	$90,738
6. Total In-Kind Contributions	$0	$0	$0

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

4. Stigma & Discrimination Reduction Campaign

County Name: Alameda — Date: 8/18/08

PEI Project Name: 4. Stigma and Discrimination

Provider Name (if known):

Intended Provider Category: Other

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	7,575
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	7,575
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
0.25 FTE Executive Director	$0	$7,500	$7,500
1.0 FTE Campaign Director	$0	$27,500	$27,500
2.0 FTE Administrative Assistant	$0	$37,500	$37,500
0.1 FTE Bookkeeper	$0	$2,500	$2,500
1.0 FTE County Liaison	$0	$34,949	$34,949
2.0 FTE Director (Outrch, Ed & Training; Media Project; Personal Empowerment & Spirituality)	$0	$67,500	$67,500
1.0 FTE Speakers Bureau Coordinator	$0	$18,750	$18,750
1.0 FTE Outreach Specialist	$0	$18,750	$18,750
0.5 FTE Media Watch Director	$0	$9,375	$9,375
0.5 FTE Website Manager	$0	$9,375	$9,375
1.0 FTE Sprituality Coordinator	$0	$18,750	$18,750
b. Benefits and Taxes @ % 30%	$0	$75,735	$75,735
c. Total Personnel Expenditures	$0	$328,184	$328,184
2. Operating Expenditures			
a. Facility Cost	$0	$34,650	$34,650
b. Other Operating Expenses	$0	$559,737	$559,737
c. Total Operating Expenses	$0	$594,387	$594,387
3. Subcontracts/Professional Services (list/itemize all subcontracts			
Misc Prof Svs (list included in budget narrative)	$0	$80,160	$80,160
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$80,160	$80,160
4. Total Proposed PEI Project Budget	$0	$1,002,731	$1,002,731
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$1,002,731	$1,002,731
6. Total In-Kind Contributions	$0	$0	$0

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

5. Outreach, Education & Consultation for the Latino Community

County Name: Alameda Date: 8/18/08

PEI Project Name: 1. Disparities in Access to Mental Health Services

Provider Name (if known):

Intended Provider Category: Ethnic or cultural organization

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	625
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	625
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
4.0 FTE Promoters (8 pos/0.5FTE)	$0	$62,400	$62,400
0.5 FTE Outreach Supervisor	$0	$12,000	$12,000
1.5 FTE Mental Health Spec	$0	$52,500	$52,500
0.25 FTE Administrative Assistant	$0	$4,688	$4,688
0.5 FTE Program Supervisor	$0	$22,500	$22,500
b. Benefits and Taxes @ % 30%	$0	$46,226	$46,226
c. Total Personnel Expenditures	$0	$200,314	$200,314
2. Operating Expenditures			
a. Facility Cost	$0	$31,185	$31,185
b. Other Operating Expenses	$0	$97,828	$97,828
c. Total Operating Expenses	$0	$129,013	$129,013
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Cultural Wellness Practices	$0	$37,500	$37,500
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$37,500	$37,500
4. Total Proposed PEI Project Budget	$0	$366,827	$366,827
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$366,827	$366,827
6. Total In-Kind Contributions	$0	$1,000	$1,000

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

6. Outreach, Education & Consultation for the Asian/Pacific Islander Community

County Name: Alameda County Date: 8/18/08

PEI Project Name: 1. Disparities in Access to Mental Health Services

Provider Name (if known):

Intended Provider Category: Ethnic or cultural organization

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	500
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	500
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
3.0 FTE Promoters (6 pos/0.5 FTE) ($31,200 annual)	$0	$46,800	$46,800
0.5 FTE Outreach Supervisor	$0	$12,000	$12,000
1.5 FTE MH Spec (3 pos/0.5FTE) ($70,000 annual)	$0	$52,500	$52,500
0.25 FTE Administrative Assistance	$0	$4,688	$4,688
0.25 FTE Program Supervisor	$0	$11,250	$11,250
b. Benefits and Taxes @ % 0.3	$0	$38,171	$38,171
c. Total Personnel Expenditures	$0	$165,409	$165,409
2. Operating Expenditures			
a. Facility Cost	$0	$27,720	$27,720
b. Other Operating Expenses	$0	$84,496	$84,496
c. Total Operating Expenses	$0	$112,216	$112,216
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Cultural Wellnes Practices	$0	$35,000	$35,000
	$0	$0	$0
	$0	$0	$0
a. Total Subcontracts	$0	$35,000	$35,000
4. Total Proposed PEI Project Budget	$0	$312,625	$312,625
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$312,625	$312,625
6. Total In-Kind Contributions	$0	$1,000	$1,000

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

7. Outreach, Education & Consultation for the South Asian & Afghan Community

County Name: Alameda Date: 8/18/08

PEI Project Name: 1. Disparities in Access to Mental Health Services

Provider Name (if known):

Intended Provider Category: Ethnic or cultural organization

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	375
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	375
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
0.33 FTE Outreach Supervisor	$0	$7,920	$7,920
2.0 FTE MH Spec	$0	$70,000	$70,000
0.25 FTE Administrative Assistance	$0	$4,688	$4,688
0.5 FTE Program Supervisor	$0	$22,500	$22,500
b. Benefits and Taxes @ % 30%	$0	$31,532	$31,532
c. Total Personnel Expenditures	$0	$136,640	$136,640
2. Operating Expenditures			
a. Facility Cost	$0	$17,325	$17,325
b. Other Operating Expenses	$0	$167,978	$167,978
c. Total Operating Expenses	$0	$185,303	$185,303
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Cultural Wellness Practices	$0	$29,700	$29,700
Outreach Workers/Mentor Stipends	$0	$20,800	$20,800
	$0	$0	$0
a. Total Subcontracts	$0	$50,500	$50,500
4. Total Proposed PEI Project Budget	$0	$372,443	$372,443
B. Revenues (list/itemize by fund source)			0
	$0	$0	$0
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$0	$0
5. Total Funding Requested for PEI Project	$0	$372,443	$372,443
6. Total In-Kind Contributions	$0	$1,000	$1,000

PEI Revenue and Expenditure Budget Worksheet

Form No. 4

8. Outreach, Education & Consultation for the Native American Community

County Name: Alameda Date: 8/18/08

PEI Project Name: 1. Disparities in Access to Mental Health Services

Provider Name (if known):

Intended Provider Category: Ethnic or cultural organization

Proposed Total Number of Individuals to be served:	FY 07-08	0	FY 08-09	300
Total Number of Individuals currently being served:	FY 07-08		FY 08-09	
Total Number of Individuals to be served through PEI Expansion:	FY 07-08	0	FY 08-09	300
Months of Operation:	FY 07-08		FY 08-09	6-months

	Total Program/PEI Project Budget		
Proposed Expenses and Revenues	FY 07-08	FY 08-09	Total
A. Expenditure			
1. Personnel (list classifications and FTEs)			
a. Salaries, Wages	$0	$0	$0
2.0 FTE Peer Counselors	$0	$31,200	$31,200
0.1 FTE Supervisor	$0	$4,500	$4,500
0.5 FTE MH Specialist	$0	$17,500	$17,500
b. Benefits and Taxes @ % 30%	$0	$15,960	$15,960
c. Total Personnel Expenditures	$0	$69,160	$69,160
2. Operating Expenditures			
a. Facility Cost	$0	$10,395	$10,395
b. Other Operating Expenses	$0	$73,386	$73,386
c. Total Operating Expenses	$0	$83,781	$83,781
3. Subcontracts/Professional Services (list/itemize all subcontracts)			
Culturally Competent Services	$0	$19,750	$19,750
Peer Mentors	$0	$10,400	$10,400
	$0	$0	$0
a. Total Subcontracts	$0	$30,150	$30,150
4. Total Proposed PEI Project Budget	$0	$183,091	$183,091
B. Revenues (list/itemize by fund source)			0
Pow-Wow vendor rental	$0	$800	$800
	$0	$0	$0
		$0	$0
1. Total Revenue	$0	$800	$800
5. Total Funding Requested for PEI Project	$0	$182,291	$182,291
6. Total In-Kind Contributions	$0	$0	$0

ALAMEDA COUNTY

Administration Budget Narrative

The Administrative Budget is based on the State's approval of Prevention & Early Intervention Plan by September 2008, thereby having staffing as of October 2008. All staffing costs are based on Alameda County's Salary & Wages budget for FY 08/09. In addition to Salary & Benefits costs, 20% was added to Salary & Benefits for Operating Expenses. Revenues were included based on either Utilization Review claiming, Medi-Cal Administrative Activities (MAA), and/or Medi-Cal Administrative claiming, as appropriate. Start Up costs, such as furniture, computers, recruitment cost were included.

Quality Improvement – Increasing administrative support capacity in our Quality Improvement Office. Staff positions will support implementation of quality improvement programs, best practices training, and the development of linkages between emerging prevention strategies and system quality improvement initiatives. Staffing includes:

- 1.0 FTE – Administrative Specialist
- 1.0 FTE – Administrative Assistant

Management Support Services – Increasing data analysis, report writing, contract management and referral capacity, as well as, a PEI Coordinator. Positions will ensure effective coordination of prevention program activities with system outcomes and specific program objectives. PEI Coordinator will have overall administrative oversight of MHSA-funded prevention programs. Management Analyst will monitor program activities through systematic measures, reporting as necessary to program management, quality improvement committee, and systems of care management. Program specialist will provide technical assistance and coordinate collaborations among PEI programs. Staffing includes:

- 2.0 FTE – Management Analyst
- 2.0 FTE – Program Specialist
- 1.0 FTE – PEI Coordinator

Older Adult System of Care – Increasing gerontologist nursing capacity for older adult programs. This position will support implementation of the PEI-funded integrated mental health and primary care program.

- 1.0 FTE – Nurse Practitioner

Finance – Increasing capacity to manage contracts and fiscal reporting required to support eight new programs funded under PEI.

- 2.0 FTE – Financial Service Specialist

Medical Director – Increasing capacity to provide quality assurance in medication management programs, particularly for the 'First Onset' program and the integration of primary care and mental health services being proposed for funding under PEI.

- 1.0 FTE – Pharmacist

PEI Administration Budget Worksheet

Form No. 5

Administration

County Alameda

Date: 8/18/2008

Months of Operation: FY 07/08: 0 FY 08/09: 6-months

	Client and Family Member, FTEs	Total FTEs	Budgeted Expenditure FY 2007-08	Budgeted Expenditure FY 2008-09	Total
A. Expenditures					
1. Personnel Expenditures					
a. PEI Coordinator		1	$0	$82,696	$82,696
b. PEI Support Staff					$0
c. Other Personnel (list all classifications)					$0
Administrative Specialist		1	$0	$53,106	$53,106
Administrative Assistant		3	$0	$126,756	$126,756
Management Analyst		2	$0	$120,617	$120,617
Program Specialist		2	$0	$117,081	$117,081
Nurse Practitioner		1	$0	$81,593	$81,593
Financial Services Specialist		2	$0	$106,212	$106,212
Pharmacist		1	$0	$104,429	$104,429
Health Educator		1	$0	$49,052	$49,052
Prevention Coordinator		1	$0	$82,696	$82,696
d. Employee Benefits				$388,469	$388,469
e. Total Personnel Expenditures			$0	$1,312,707	$1,312,707
2. Operating Expenditures					
a. Facility Costs			$0	$77,963	$77,963
b. Other Operating Expenditures			$0	$189,404	$189,404
c. Total Operating Expenditures			$0	$267,367	$267,367
3.County Allocated Administration					
a. Total County Administration Cost			$0	$0	$0
4. Total PEI Funding Request for County Administration Budget			$0	$1,580,074	$1,580,074
B. Revenue					
1 Total Revenue			$0	$478,871	$478,871
C. Total Funding Requirements			$0	$1,101,203	$1,101,203
D. Total In-Kind Contributions			$0	$0	$0

Form No. 6

County:	Alameda
Date:	8/18/2008

		Fiscal Year			Funds Requested by Age Group			
#	List each PEI Project	FY 07/08	FY 08/09	Total	*Children, Youth, and their Families	*Transition Age Youth	Adult	Older Adult
1A	Mental Health Consultation in Schools/ Preschools - PreK	$0	$106,162	$106,162	$106,162			
1B	Mental Health Consultation in Schools/ Preschools - Elementary & Middle	$0	$267,767	$267,767	$267,767			
1C	Mental Health Consultation in Schools/ Preschools - High Schools	$0	$117,402	$117,402	$79,833	$37,569		
2	Early Intervention at the Onset of First Psychosis & SMI Among TAY	$0	$580,519	$580,519	$87,078	$493,441		
3A	Mental Health-Primary Care Integration for Older Adults - Latino-Serving Clinic	$0	$241,297	$241,297				$241,297
3B	Mental Health-Primary Care Integration for Older Adults - API-Serving Clinic	$0	$241,297	$241,297				$241,297
3C	Mental Health-Primary Care Integration for Older Adults - ERs	$0	$90,738	$90,738				$90,738
4	Stigma & Discrimination Reduction Campaign	$0	$1,002,731	$1,002,731	$330,901	$160,437	$381,038	$130,355
5	Outreach, Education & Consultation for the Latino Community	$0	$366,827	$366,827	$143,063	$62,361	$143,063	$18,341
6	Outreach, Education & Consultation for the Asian/Pacific Islander Community	$0	$312,625	$312,625	$84,409	$59,399	$121,924	$46,894
7	Outreach, Education & Consultation for the South Asian Community	$0	$372,443	$372,443	$108,008	$55,866	$167,599	$40,969
8	Outreach, Education & Consultation for th Native American Community	$0	$182,291	$182,291	$27,344	$32,812	$78,385	$43,750
--	Administration	$0	$1,101,203	$1,101,203	$352,385	$253,277	$253,277	$242,265
--	**Total PEI Funds Requested:**	$0	$4,983,302	$4,983,302	$1,586,950	$1,155,162	$1,145,285	$1,095,905

County: Alameda **Date:** 8-18-08

☐ Check this box if this is a "very small county" (see glossary for definition) and the county is electing the option to waive the requirement to conduct a local evaluation of a PEI project. Very small counties electing this option do not need to complete the remainder of this form.

PEI Project Name:

1a. Identify the programs (from Form No. 3 PEI Project Summary), the county will evaluate and report on to the State.

This evaluation will address Component B, the treatment program, of the Early Intervention for the Onset of First Psychosis and Serious Mental Illness (SMI) Among Transition Age Youth (TAY) Project.

1b. Explain how this PEI project and its programs were selected for local evaluation.

This PEI project and its programs were selected for local evaluation due to a number of factors:

i) This project has been identified by national models that have shown positive outcomes such as reducing recurrent psychosis among transition-age youth
ii) Though this project has been identified as a best practice, it has yet to be evaluated in an ethnically diverse area such as Alameda County
iii) Measurements to evaluate this project have already been developed at other sites. We will use their technical assistance to tailor an evaluation for Alameda County.

2. What are the expected person/family-level and program/system-level outcomes for this program?

Person/family level:

- Improved individual and family functioning
- Formation of positive relationships
- Successful self-management of symptoms and a decrease of negative symptoms
- Engagement of families in treatment
- Ability to function independently with a focus on educational and vocational goal

Program/system level:

- Clinicians in the program will be trained on the instruments to measure generalized functioning for example; Global Assessment of Functioning (GAF) and Structured Interview for Prodromal Syndromes (SIPS) instruments
- Improvement in level of functioning will be measured at admission and periodically using the GAF and the SIPS
- Early, more timely and more comprehensive response to referrals of TAY who may be at-risk for psychosis.
- Over time, a decrease in the number of TAY with repeated episodes of untreated psychosis.

- Lower hospitalization rates for TAY with First episode Psychosis

3. Describe the numbers and demographics of individuals participating in this intervention. Indicate the proposed number of individuals under each priority population to be served by race, ethnicity and age groups. Since some individuals may be counted in multiple categories, the numbers of persons on the chart may be a duplicated count. For "other", provide numbers of individuals served for whom a category is not provided (i.e., underserved cultural populations; e.g., gay, lesbian, bisexual, transgender, questioning; hearing impaired, etc.). Please indicate at the bottom of the form an estimate of the total unduplicated count of individuals to be served. If the focus of the intervention is families, count each person in the family.

PERSONS TO RECEIVE INTERVENTION/YEAR

POPULATION DEMOGRAPHICS	PRIORITY POPULATIONS						
	TRAUMA	FIRST ONSET	CHILD/ YOUTH STRESSED FAMILIES	CHILD/ YOUTH SCHOOL FAILURE	CHILD/ YOUTH JUV. JUSTICE	SUICIDE PREVENTION	STIGMA/ DISCRIMINATIOn
ETHNICITY/ CULTURE							
African American	11	18	11	11	11	18	18
Asian Pacific Islander	5	10	16	7	6	10	10
Latino	6	9	6	8	6	9	9
Native American	<5	<5	<5	<5	<5	<5	<5
Caucasian	12	20	12	12	12	20	20
Other (Multirace/South Asian/ LGBTQQI/Physically Disabled)	<5	<5	<5	<5	<5	<5	<5
AGE GROUPS							
Children & Youth (0-17)							
Transition Age Youth (16-25)	36	60	32	40	36	60	60
Adult (18-59)							
Older Adult (>60)							
TOTAL	36	60	32	40	36	60	60
Total PEI project estimated ***unduplicated*** count of individuals to be served/year: 60							

4. How will achievement of the outcomes and objectives be measured? What outcome measurements will be used and when will they be measured?

Outcomes and objectives will be measured through the following types of tracking and evaluation tools:

- Intake Assessment with demographic information, such as age, referral source, ethnicity/cultural background and change in quality of life instruments (GAF and SIPS) scores over time
- Family engagement measurement instruments
- Monthly monitoring of height, weight, blood pressure and side effects for TAY on medications
- Satisfaction and self-assessment surveys
- Hospitalization rates and length of stay measurements
- Number of days at school and/or at work
- Follow-up interview or survey with those seen for clinical services
- Interviews or surveys with diverse key informants working with TAY

5. How will data be collected and analyzed?

The framework for collecting and analyzing the data will be set-up and maintained by the Evaluation Director in collaboration with the Data/Media Analyst. Evaluation consultants may also assist in creating this framework during program start-up.

6. How will cultural competency be incorporated into the programs and the evaluation?

Cultural competency will be incorporated into the programs and evaluation through linkage with existing community organizations that currently provide culturally and linguistically appropriate education and outreach to TAY. Increase in the level of capacity will be demonstrated by a growing network of providers with cultural expertise in working with TAY and TAY sub populations. Many community organizations have developed culturally appropriate ways to reach their youth, and collaborations with these organizations would build on those customs. For example, the Native American community uses rituals and custom to promote healing and a sense of community for youth. Focus groups would also be conducted during program start-up to discuss ways that evaluation outcomes and objectives for this project might differ by cultural group.

7. What procedure will be used to ensure fidelity in implementing the model and any adaptation(s)?

The Executive Director and Clinical/EPB/Evaluation Director will consult with experts already implementing this model to map out, in detail, the expected implementation of this program locally. Both of these staff will also be responsible for reporting any changes or adaptations to this local model and the key reasons behind any change or adaptation in their regular progress reports.

8. How will the report on the evaluation be disseminated to interested local constituencies?

A summary of the evaluation results will be posted on the BHCS website annually and a detailed write-up of the evaluation results will be available by request from the Executive Director. An announcement will be sent-out to lead staff of other MHSA projects and projects serving TAY each year when the updated results are posted. Meetings will be held twice a year with project staff to discuss the evaluation results and determine whether any program modifications should be made based on the most recent evaluation results. One of these meetings will cater to an expanded audience to include family representatives and members of the TAY Advisory Board, Transition-Age Team (TAT), and BHCS Administration.